THE SURVEY

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The Gist of It

WHY medical care seems so crushing an item in middle-class budgets, while hospitals labor under deficits and doctors seem no richer than the rest of us, is the dilemma considered by sixteen eminent observers in this special issue of Survey Graphic. In succeeding months we shall follow current proposals and experiments to provide medical care with equity to all and at a cost which each can afford. The editors are indebted for help to many advisors and collaborators, especially to MARY ROSS of our editorial staff and to the Committee on the Cost of Medical Care. Articles express their authors' opinions as individuals without committing in policy their organizations.

HAVEN EMERSON, M.D., health editor of Survey Graphic, professor of public health administration at Columbia University, describes on page 373 the historical backdrop behind today's scene in medical history.

ON page 375 DR. GEORGE EDWARD FOLLANSBEE of Cleveland, a private practitioner and chairman of the judicial council of the American Medical Association, presents the case of conscientious physicians who deal with middle-class patients.

AS economist and also as patient and parent, WALTON H. HAMILTON of the faculty of Yale Law School, tells on page 380 why medical costs appear to be an economic anomaly.

DR. LOVELL LANGSTROTH of San Francisco (page 384) observes as a private practitioner how many patients make trouble and expense for themselves.

MARY LOUISE MARK, professor of sociology at Ohio State University, analyzes on page 386 the costs involved in the advent of 540 run-of-the-mill babies.

TO the problems of medical organization EDWARD A. FILENE brings (page 389) the principles of distribution which he has employed so brilliantly as president of William Filene's Sons Company in Boston.

THAT public health and private practice have everything to gain by joining hands is the belief of SHIRLEY W. WYNNE, M.D., commissioner of health of New York City. Page 394.

PHILIP KING BROWN (page 398), medical director of the Southern Pacific Railroad, describes that company's services for its thousands of employes and the health of the community.

CARROLL P. STREETER, who tells on page 402 how communities pay in rural Saskatchewan, is a member of the field editorial service of The Farmer's Wife.

NEW wine in the old bottles of Lebanon is the story recounted on page 405 by STUART CARTER DODD, professor of sociology at the American University of Beirut.

C. RUFUS REM, formerly of the faculty of the University of Chicago, now of the research staff of the Committee on the Cost of Medical Care, considers on page 410 some principles of group medical practice.

WHOLESALEING health as well as promoting research have been among the outstanding contributions of the great American philanthropic foundations, described on page 413 by EDWIN R. EMBREE, formerly of the Rockefeller Foundation, now president of the Julius Rosenwald Fund.

MICHAEL M. DAVIS, director for medical services of the Julius Rosenwald Fund, discusses (page 419) a study of moderate-priced hospital and clinic services by Professor Niles Carpenter of the University of Buffalo.

ON page 424 WADE WRIGHT, M.D., assistant medical director of the Metropolitan Life Insurance Company, demonstrates that the subject of group health insurance can be made not only important but entrancing.

WHAT the profession of nursing is doing to adapt its services to midle-class needs is told on page 426 by JANET GEISTER, R.N., director of the American Nurses' Association.

AS a statesman and administrator, secretary of the Department of the Interior; as an educator, president of Leland Stanford University; as a physician himself, knowing the problems of medical practice at first hand, DR. RAY LYMAN WILBUR has brought to the leadership of the Committee on the Cost of Medical Care (page 429) a combination of qualities seldom found this side of Utopia.

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Courtesy Dr. Baer and the Children's Hospital School, Baltimore

THE CHILDREN'S SURGEON

A generation of doctors have hung on their walls, a generation of patients have come to love the picture of the bearded doctor who contemplates by lamplight the sick child lying on a cot made of two chairs, while the anxious parents wait in the background. In the fine portrait above of Dr. William Stevenson Baer, painted by order of his board of trustees for the Children's Hospital School in Baltimore, by the distinguished English artist, Harold Knight, we have a worthy modern successor to that scene of the sentimental past. The large, skilled hands, the strong head, the poise, give a feeling of quiet competence. The surgeon's apron stands out against the dark background while light falls significantly upon the sleeping child in the hospital crib and upon the watchful doctor.

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THE SURVEY
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Health — the Business of Each of Us

By HAVEN EMERSON, M.D.

THE perfect alibi will never be found for health. However loudly we shout Public Health from the housetops, it is our own personal health we are concerned with, and we can no more attain it by hiring a health officer or by buying Christmas seals than we can heal a broken bone by proxy, or engage a civil service superintendent of hospitals to have our attack of appendicitis for us.

There was a time, and not out of the memory of grandparents now living, when health was an accident of residence, of family, of station in life, and likened to any other divine blessing, unattainable by merit or striving, a gift of the gods and yet but little appreciated.

Then came the first era of self-determination when it was the community custom to hire a sanitary trouble-fixer, set up a board of health, make ordinances about sewer gas, general untidiness and people with smallpox, and then settle down to a life of closed windows, polluted wells, overfeeding and gin.

The Victorian health officer of this earliest sanitary era of public health was as a voice crying in the wilderness, a devotee of Aesculapius burning incense to unknown gods, fumigating myths, abating pigpens and generally prosecuting offenders against contemporary sanitary opinion. Among these valiant crusaders were the great sanitarians of clean water and decent waste disposal. They accomplished miracles by the engineering route upon a quite unconscious public, ignorant of the most elementary facts of disease prevention. There was usually but one person in any city concerned with health and he a student of sickness and death, an inquirer into conditions of premises rather than of personal contacts, and relationships of public principles rather than personal practice.

Rather suddenly the scenery shifted and the stage was peopled with a lot of eager coadjutors, salesmen of a new miracle of knowledge. A little group of friendly visitors, and physicians, and pathologists began to dramatize happy news which they were bursting to share with all the world. Said they, "Tuberculosis is communicable! CURABLE!! PREVENTABLE!!!" and they set about informing everyone of the causes, early signs, and ways of stopping the greatest handicap of their generation, galloping consumption. Here was a new idea, a novel force, a welcome auxiliary battalion to reinforce the lone general of the health department.

Thus a second era born with this century opened undreamed of possibilities, now the commonplaces of every day health practice, and the building publicists of the day viewed through distant vistas a millenium of longevity. Have we not for almost a generation been pushing out and over a population now almost drowned in a wealth of facts, wave after wave of health propaganda? After a great success with snatching babies from impending death by teaching mothers what and when to feed them, our attention was seized by adepts in social and moral prophylaxis who found that the time was opportune to attack venereal disease by information and discussion, rather than by ostrichism and discretion; the procession lengthened, and we have today a grand array each under a noble banner—mental hygiene; cancer control; prevention of heart diseases, blindness, and tuberculosis; social hygiene, and child health.

IN this issue of SURVEY GRAPHIC we invite your thought towards the future in the spirit of the authors who offer you of their testimony and their wisdom. We have here no controversy or spirit of antagonism of schools or creeds, schisms of the spirit, or rivalry for material gains, no outburst of malicious criticism, nor ponderous propaganda. In the spirit of friendly searching for jewels in the treasury of knowledge, these men, notable as persons as well as for the professional and other organizations they so well represent, turn over in their minds and in your presence many vexing questions of patient and doctor, health officer, nurse, sickness, growth, recovery, cost, charity,

So Say We All

The one great outstanding problem before the medical profession today is that involved in the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations of life.—Olin West, M.D., *secretary and general manager of the American Medical Association.*

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tax, freedom of choice, compulsion of law, hospital, dispensary, panel, insurance. These are but terms, symbols of social practices, and not yet well located in our manners of thought and conduct.

Compulsion is strikingly absent from among the solutions in various gentle ways suggested by the description of successful experiments. Perhaps we are recovering from the cruder phases of legalism as a social force and are now voyaging upon the two through routes of education and common interest to bring us home to health. Our good-natured contributors, who for the moment are the faculty of our universal college rather than staff officers of any army of reform, put before you not experiments, but experiences and observations. They approach by the relation of the variables rather than by assuming fixed points in the situation.

The dangerous formalities of standardization of needs or services are not proposed by any of our authors. They find us vexed, they admit the perplexities of a situation the very antithesis of good bargaining, for patients on the whole either do not know what they want and need, or from whom to get it at a cost within their habit of payment; and physicians find investment in their training and equipment so costly that they are put to it to come out even in their old age after a life of somewhat exacting responsibilities. Both parties feel a bit aggrieved and tend to vent their spleen upon the other fellow. Neither has viewed generously his partner's dilemma. Furthermore, the controversy rages not only between doctor and patient but between patient and nurse, and for rather similar reasons. Private duty nursing is far too expensive for most of those who feel they need it, and yet the vicissitudes of seasonal disease cause the nurse endure the modified poverty of periodic unemployment.

History and foreign example are not held up to us for admiration, to be copied, and it would seem to be tacitly accepted that what there is of American social genius is faced with the rare opportunity of creating its own precedents.

HEALTH is quite as much a social as a personal necessity, and if this is admitted there is no dodging the individual and collective privilege and hence duty of attaining as much of it as the medical and social sciences have to offer us. Voluntary joint action has hardly been tried, and yet it would seem to offer great rewards in a way quite as promising in medical care as the cooperative production and purchase of necessities has proved to be under the Rochedale system. With probably at least 90 per cent of the sickness among city and rural people of the United States from causes quite out of the scope of organized official and volunteer health agencies, it is distinctly the job of the family man and his wife, the butcher, the baker, and candlestick-maker to give at least as much thought to the quantity and quality of medical care they purchase as they do to schooling and clothing today.

Knowledge is pooled, but its distribution for use is much after the fashion of mists and April showers. It is time the users tapped the pool with a strong pump and laid the pipes to every house, with pressure enough to reach each level of our sky-scraping plan of living. Even where the water of wisdom is not within sight to refresh the passerby with its reflection of clear heaven, there is the steady flow of deep ground streams to be tapped by courageous diggers.

SURELY medicine has its fundamentalists, its sectarians, trades unionists, its codists, who are forever seeking victims among the nonconformists. While bacteria and the still more evasive ultramicroscopic viruses of disease contrive to exhibit a catholicity of conduct according to the age-old free-for-all of biological combat, the man of little mind, the state's right apostle, calls upon vindictive law to forbid the interstate traffic in physician's services. Valiant Rhode Island has but recently blown itself into a very Texan bulk with the windy complaint that visiting wise men must not offer their wares however briefly or for however puny and stunted a childhood lest the privilege and profits of local doctors be in some way abridged. And in the city of racketeers we find a much respected physician ousted from the society of his fellows because he has conformed his professional work to a personal standard of ethics instead of to a code promulgated by the group.

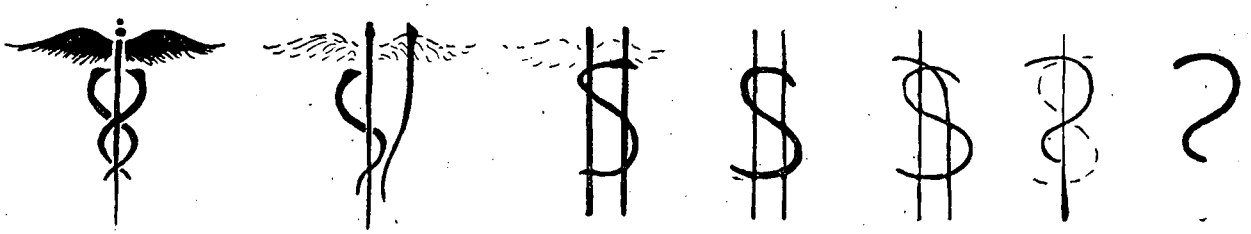
These are but minor eruptions disclosing the discord which is here and there sedulously cultivated by coteries who seem to exhibit inferiority complexes at a moment's notice. The care of the sick, the cultivation of health gain nothing by creating barriers to the free circulation of medical information whether free or at a price. Nor will the evils of self-advertising or the dangers of pay-clinic commerce with the sick be abated by making a martyr of a physician licensed by the commonwealth to practice his science with art among the people.

While the business of health is one for all of us and is of deeper import than any of the internecine quarrels between the men and institutions in medicine, we must note the symptoms of disorder which tempt the ready pencil of the lay reporter. Coordination of individual skills under group clinics has been attacked and much of the merit in this method of practice has been obscured thereby. There has been also a kind of sabotage, more passive or vocal than aggressive, and functioning by practitioner groups against the works of health agencies and officers, who in most instances are but putting into effect the advice of the leaders in medical thought.

Fortunately these are little more than the expressions of a somewhat too standardized conception of the social role of medicine in an age bursting with new desires and necessities. Perhaps the thoughts of those who shape the policies of the future for health and the relief of the sick will bear in mind two brief messages of Confucius.

"The great attribute of heaven and earth is the giving and maintaining of life."

"While you are not able to serve men, how can you serve their spirits?"



Drawing by Florence Marvyne Bauer

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A Doctor Diagnoses the Bills

By GEORGE EDWARD FOLLANSBEE, M.D.

Drawings by Florence Marvyne Bauer

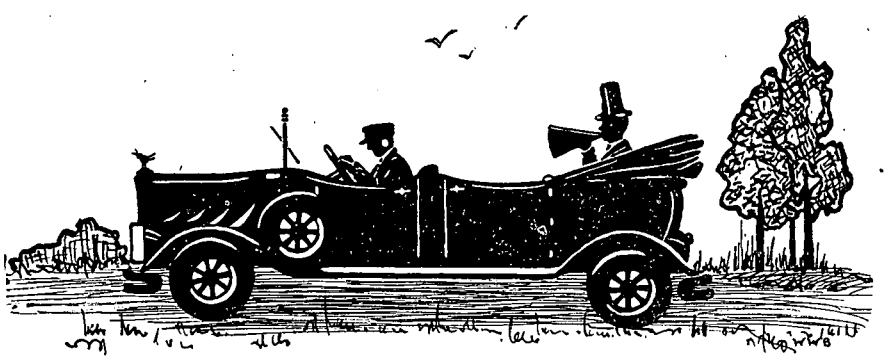
THE medical profession is composed of very human beings who vary as widely in character, ideals, ambitions, motives, mental processes, and economic and spiritual necessities as any other large group of people.

Many enter the profession because of their love for scientific research, many from purely humanitarian or religious motives. Probably a large percentage choose medicine because it seems to offer an agreeable and fairly certain means of earning a comfortable living; it is doubtful if there are any who expect to become wealthy. The individual approach of physicians toward all that has emanated concerning the cost of medical care therefore would be divergent at the outset of their careers. Having started, they are divided still further in their outlook by such influences as the personality of instructors, enthusiasm for the work itself, the kind of people among whom they practice, the character of their immediate associates or the departments of medicine in which they practice, and their opportunities in practice, such as salaried positions, and the like. Consequently, the profession is not a unit in its attitude toward the cost of medical care any more than it is on any other problem, professional, economic or social.

The lives and fortunes of the great majority of doctors are primarily and necessarily bound up with and dependent on the "great middle class" on whose behalf so much has been written. Hence the thoughts and views of this great section of the profession, represented by organized medicine, should be chiefly considered. The views and opinions of the small number who are commercially minded and selfish beyond the bounds of professional ideals need not be considered at all. The opinions of those whose practice is not definitely influenced by this "middle class" problem should be considered with the distinct realization that they are not materially affected by it; that they are "back-seat" drivers. They are good drivers, probably, but still the results of the driving are not theirs to be borne.

I am attempting here to present the side of the great majority of the practitioners for the "middle class" who are professional in their ideals, who love their work, who have a friendly interest in their patients, whose love for their profession makes them jealous for its continued scientific advancement, whose living is dependent upon their practice, and who believe that although doctors are humanitarians they are entitled to an income sufficient to support their families in comfort, to educate their children and to lay aside during their years of activity sufficient to care adequately for them in their declining years.

Many complaints have appeared in magazine articles and newspaper editorials about the "high cost of medical care." Most of these articles have been by laymen not entirely conversant with the most important feature of the prevention and cure of disease—the doctors' part. They have failed to recognize the personal relationship existing between patient and doctor in the application of the science of medicine, constituting the art of medicine. Personal art shares with impersonal science in the success of the practitioner of medicine. The doctor has had little to say except to his fellow practitioners and in his professional publications. Not that he is indifferent, but primarily because he does not know the facts which must be known before a proper cure, if any is needed, can be found, and secondarily because he has been widely charged with commercialism as a cause of the condition and ordered to correct it himself or take the consequences of a correction by the public — a charge which he knows has



Doctors uninfluenced by the middle class are back-seat drivers

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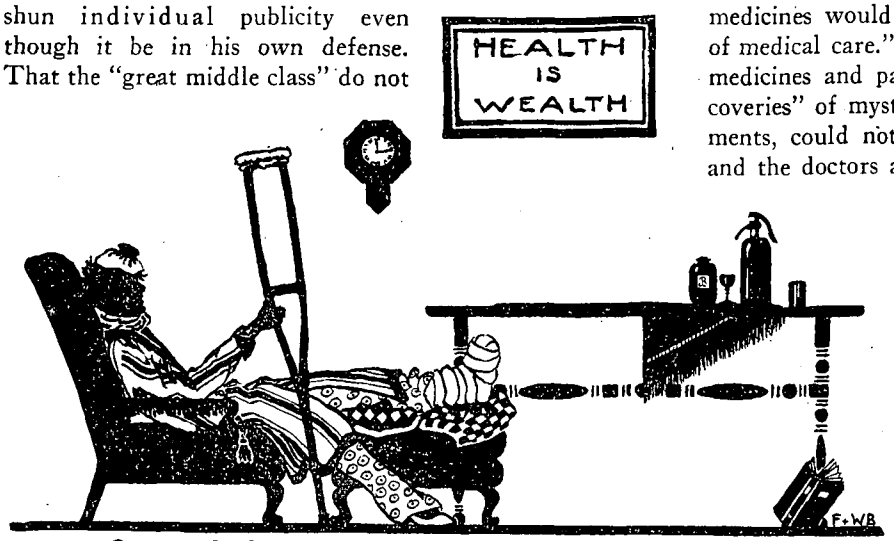
little foundation in fact, but which he cannot refute until all the factors are known. Furthermore, his nature and his training are such as to make him shun individual publicity even though it be in his own defense. That the "great middle class" do not have or do not pay for adequate medical care is a fact which is well recognized by the profession, but the reasons are not known because the underlying facts have never been determined. The opinions as to cause which have been expressed are based on guess-work, sentiment and emotion, except in rare instances which are not typical of the situation as a whole and are therefore misleading.



One can be happy without fur coats but not without health

Much consideration has been given to the problem by the profession as individuals and by the national, state and local organizations, and some suggestions involving the methods of the practice of medicine have been made and put into effect. Many organizations are investigating various phases of the problem and numerous experiments are under way. The entire subject is at present under thorough survey and analysis, national in scope, by the Committee on the Cost of Medical Care, with which the profession is actively cooperating through its national and local bodies and on which it is represented by a number of actively interested, influential members. The progress made by this committee is slow, for the task is gigantic in its various ramifications and actual statistical facts are few, but it is hoped that patient, careful, accurate surveying and honest, judicial consideration of the facts when known will present the problem in its true light to both laity and profession and will point the way to a just, equitable and satisfactory solution. Let it be understood that medical organization representing the profession is not indifferent nor antagonistic but is as much concerned as the representatives of the laity, though not so audible.

Many items enter into the cost of keeping and getting well —that expense broadly called "cost of medical care" and usually emphasized by the descriptive term "high." To the majority of people the items comprising this cost in the order of the percentage of their participation are doctors' fees, hospital charges, nursing expense, drugs, dressings and appliances, and all other expenses.

No one knows just how much is spent by families for patent medicines but the family practitioner in his contact with the families believes the amount will closely approximate that paid to doctors, especially in the country where people are more inveterate patent medicine takers than in the city. Nothing has been said about patent medicines as a factor, but as self-prescribing of patent medicines is generally not only useless but often actually harmful it is a conservative statement to say that the elimination of patent medicines would materially reduce the burden of the "cost of medical care." It is well known that the ordinary patent medicines and particularly their allies, the "wonderful discoveries" of mysterious devices and medicines curing all ailments, could not exist a year were it not for advertising; and the doctors are unable to credit with sincerity the publishers who, knowing the uselessness and harmfulness of these preparations and systems, line their pockets with ill-gotten gains from advertising them, and at the same time attack the profession for the "high cost of medical care."

If, as is generally supposed, doctors' fees are the preponderating item making adequate care impossible, it would follow that a vast sum is flowing into the pockets of the medical profession. No accurate figures of physicians' incomes are available. Many widely varying guesses and estimates have been made. Each doctor knows comparatively and probably fairly closely the incomes of his fellow practitioners. His guess is that the income of the large proportion of the profession will average in the neighborhood of $5,000 to $6,000 a year. He knows there are some doctors whose expenses are greater than their incomes, and that many doctors are realizing much more than the average, a few collecting possibly $75,000 and an occasional one up to $100,000. The high-income doctors have no place in this discussion. Their practice is not among the "great middle class." An income of $5,000 to $6,000 a year does not appear to be excessive for a man who has spent his life up to twenty-eight years of age in study and preparation and some $12,000 in expense before he begins his earning. He is entitled to $720 per year interest on what he has invested to become qualified, and he begins to earn at an age when in other fields the young man is well established. If the cost of medical care is beyond the ability of people to pay, the profession cannot be charged with the major responsibility.

It is true that there are in the profession a small minority who capitalize the fears of their patients, exaggerate the importance of their own services, advise and execute unneces-

Patent medicines are large items in the "high" cost

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sary procedures, charge all and more than their patients can pay and in fact, prey upon them; but these men are few, though the great majority must bear the odium of their conscienceless methods. For a long time the profession, through its national body, has declared that to contract to treat patients at an amount insufficient to give proper service is unethical, and there is a growing belief that it should be equally unethical to charge more than services are worth. Exorbitant charges and commercial-mindedness are as much frowned upon by the profession as a whole as by the laity.

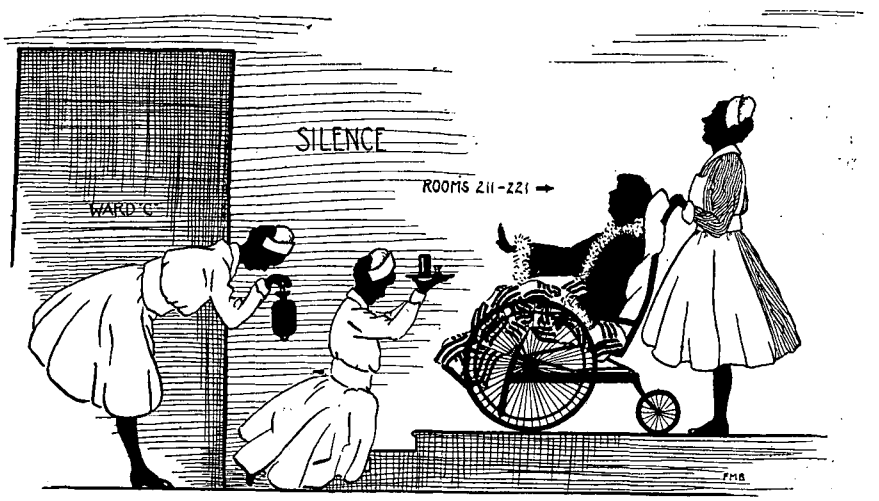
Hospital expense has risen in the last few years and has added its quota to the total expense of being sick. This increase is justified on the basis of higher operating costs, more efficient service, expanding facilities in diagnosis and treatment and enlarged demands on the part of patients. Hospitals have been compelled by the advance in medical science to improve their practice and facilities. A hospital equipped and operated as was standard ten or fifteen years ago would be shunned by the patient of moderate means today. He would be no more satisfied with it than he would be with an automobile of 1919 model. Today's patient, be his means ever so moderate, demands today's hospital as well as today's radio and car. Furthermore, he demands services he has heard about, such as x-ray examinations, metabolism tests and laboratory work whether he really needs them or not, and he demands his special nurse, far too often unnecessarily, and often against the advice of his attending doctor. He frequently enters a private room when a cheaper semi-private or ward bed would do as well. When going to a hospital the attitude of mind of the patient and his family too often is "the best is none too good," instead of "what do I really need?" "what can I afford?" And people are going to hospitals more frequently than they did. The small apartment and the difficulty and expense of obtaining house servants as well as the vogue of hospital care contribute to this trend. In spite of all this, public hospitals are operated at a deficit.

The nurses are not getting rich at the expense of the people. Ordinary hospital nursing service is included in the bed charge, so that nursing from the standpoint of the cost of medical care is confined to the private duty nurse only. The average charge is about seven dollars per day, which means at the end of the year perhaps $1,400, an income not greater than that of a day laborer of whom one does not demand three years of training after a highschool course. A nurse is very fortunate if she is employed three-fourths of her time. Most nurses have work but little more than half the time. A nurse cannot support herself as she should on less. The doctor knows that special duty nurses are employed far more often and longer than they are needed, but patients are loth to dispense with them even if their services may be nothing more than those of a maid.

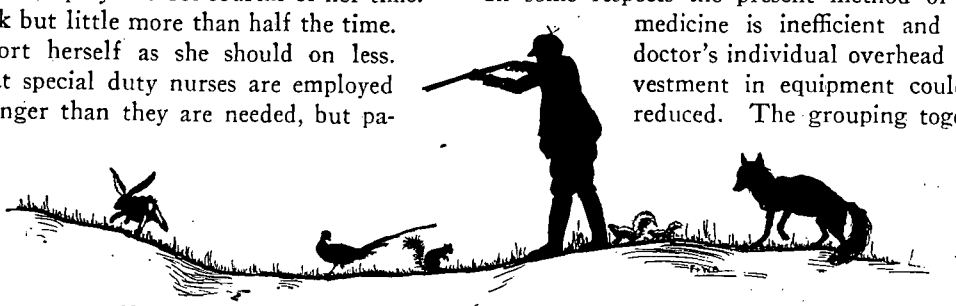
As the doctor sees it, much of the cost of care of illness is due to useless and harmful self-medication and unnecessary and unjustifiable expense at the desire of the patient himself. To the profession it seems that the family which used to save and lay aside the modest bank account for the inevitable rainy day now hardly exists; that the family now must have what it wants if it can be gotten by hook or crook. Daily necessities which must be paid for are paid to keep credit good, and the balance of the monthly income is allotted to instalment purchases. When the greatest necessity of all, health, must be purchased, little if anything is left with which to buy, but yet "the best is none too good." Sickness in such a case is a catastrophe, especially if it seizes upon the wage-earner, and usually it is cared for as are catastrophes—seldom with justice to doctor, hospital or nurse.

The complaint is made about the high cost of *sickness*. Is not the complaint actually about the high cost of *health?* When looked at in this way, the complaint sounds less reasonable. Health is as much of a necessity of life as shelter. One can be happy without fur coats, radios, over-stuffed furniture, automobiles, bootleg booze, vacuum sweepers, and the score of unnecessary trifles that make life easier and more pleasant, but one cannot be happy without health. Perhaps health costs too much for people of moderate means to be able to pay for it what it is worth and what it should reasonably cost, but that proposition has not yet been demonstrated and cannot be until health is approached as a necessity of life as are food, warmth, clothing and shelter.

In some respects the present method of the practice of medicine is inefficient and wasteful. The doctor's individual overhead expenses and investment in equipment could be materially reduced. The grouping together of doctors with the sharing of expense for necessary equipment which is but infrequently used, the arrangement of



"My own experience has been that the patient in a well-planned ward, giving a moderate degree of privacy, on the whole will make a quicker recovery than in a private room with two attentive nurses who unobtrusively, in caring for the physical needs and increasing the happiness of the patient, may suggest a mental state in which the disease condition is exaggerated sympathetically."—Dr. William Mayo *before the American College of Surgeons, Chicago, October* 14, 1929



Shall doctors be game for hunters of something for nothing?

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Pride Before a Medical Fall

PRIDE even in sickness goes before a medical fall in illness. Emotional anxiety and love for the sick person is apt to overwhelm every other consideration, and the family does not become practical until the illness is over and the bills come in. And when the bills do come in, the physician is apt to scale his fee, but the hospital, being a business institution, expects payment on the basis of its usual rates. Meanwhile, many a patient in moderate circumstances could have gotten a semi-private bed, or one in a ward, and have received just as good service, but pride has great influence and a loud voice.—*Stewart R. Roberts, M.D.*, Meeting of the American College of Surgeons, Chicago, October 14, 1929.

office hours so as to keep in continuous employment the office space, the office help, the laboratory, the telephone and the library would make a worth-while reduction in the expense of practice and permit a reduction in the fees charged, without a loss of income. The grouping of doctors into well balanced clinics with the requisite specialists is an established method of giving complete medical care to ambulatory patients at a lower rate than through individuals practicing alone, and this plan could well be extended to the care of house and hospital bed patients with even more marked reduction in cost than to the ambulatory case. In such a plan the factor of the personal relationship of the doctor to the patient, which is so important a feature in the treatment of the sick, need not be lost and would not be lost were bed patients cared for.

The profession is experimenting with various adaptations of these general plans with more or less success according to the individuals in the groups and the type of population served. The problem has received serious consideration by the leaders of the profession and the present president of the American Medical Association has traveled widely, urging the county medical societies to establish group clinics for the treatment of patients of limited means, as one answer to the demand for a decreased cost of maintaining health. Several medical societies have established such clinics, but it is too early to say with what effect. The elimination of individualized practice and the establishment of groups and clinics is not without serious defects. There is a strong tendency toward a division of responsibility, a restriction of effort to particular departments, a loss of initiative, especially on the part of the younger men, and a machine-like process in which, to the disadvantage of the patient, the art of medicine becomes lost and because of which the expense in many cases may be unjustifiably increased instead of decreased.

Unfortunately, for often the most scientific physicians are the poorest practitioners, the science of medicine is rapidly replacing rather than complementing the art of medical practice, and as practice becomes more and more an exact science the expense increases both to doctor and patient. It is the desire of the profession to give the best that is known as it is the desire of the patient to receive it. But scientific, exact diagnosis and treatment is expensive to learn and expensive to apply. Its fundamentals, theories and technique are taught in the medical schools, but its application must be taught at the bedside.

It is at this point that two leading medical organizations, the American Medical Association and the American College of Surgeons, both primarily interested in the improvement of scientific medical practice, have added their quota to increase the cost of medical care, but while doing so have improved the quality of attention given to the people. By its insistence that a hospital, to obtain recognition as a place qualified to train internes, shall have a staff and equipment suitable for that purpose, the American Medical Association has made the care of the patient in that hospital just that much better but at just that much more cost. By establishing its standard for recognition as an approved hospital, the College of Surgeons has raised the cost of the care of the patient, but it has also vastly improved the quality of the care given. The results obtained by both these organizations, although the expense to the hospital patient has been increased, have been greatly to improve the quality of service given to the people at large because of the better doctors that have been made by the training in better hospitals.

But better doctors cost more and are worth more. They cost more to make and they cost more to maintain. The expense of equipment for the modern practice of medicine and for keeping pace with medical progress is no small item in the doctor's budget. To use a homely analogy, the medical schools and hospitals in response to public demand are turning out electrically operated vacuum-sweeper doctors. Fifty years ago a fifteen- to twenty-five-cent broom was a satisfactory cleaner. Thirty-five years ago families who could afford it paid three to five dollars for a carpet sweeper. For the last few years all who can afford it (and many who cannot, as doctors can testify) have a fifty- to seventy-five-dollar vacuum cleaner. People want and need the efficient and expensive doctor, they want the expensive cleaner, but the doctor is a necessity and the vacuum sweeper a convenience. There is no question as to the choice between them should the need for both arise, but unfortunately salesmanship impresses the daily need for one while the need for the other is never impressed except by its arising. Consequently, provision is made for the one, but for the other a happy, optimistic wish and gamble that the need will not arise, is apparently the only thought, if any, that is given to it. Instalment payments for insurance against sickness or periodic deposits in savings accounts for sickness are as much more obligatory, morally, than many instalment payments (that help, incidentally, to cause the cry against the cost of medical care) as the necessity for the one is greater than for the other. Such insurance or such savings accounts would do much to lessen the apparent need for relief.

THE doctor reads in the magazines the harrowing tales of the $500 (few of them), $1,000 and up, charges of medical men with the attendant hospital expenses that have reduced respectable, self-respecting families to worse than penury, and marvels at them. He does not disbelieve the statements but he cannot comprehend them. When he thinks of his income (and a small percentage of doctors, specialists included, are collecting over $20,000 a year) he cannot visualize such charges. He knows those charges in the case of "middle class" people are so exceptionally exceptional that they form no basis for complaint against medical practice as a whole. He does not deny that there may be just cause to complain against the total cost of being well, and that some portion of that complaint may be justly made against doctors, but it is not because of such exceptional fees. He wonders why people go to strangers and purchase an operation without inquiring the price or without any arrangement for payment. They could not so purchase real (*Continued on page* 441)

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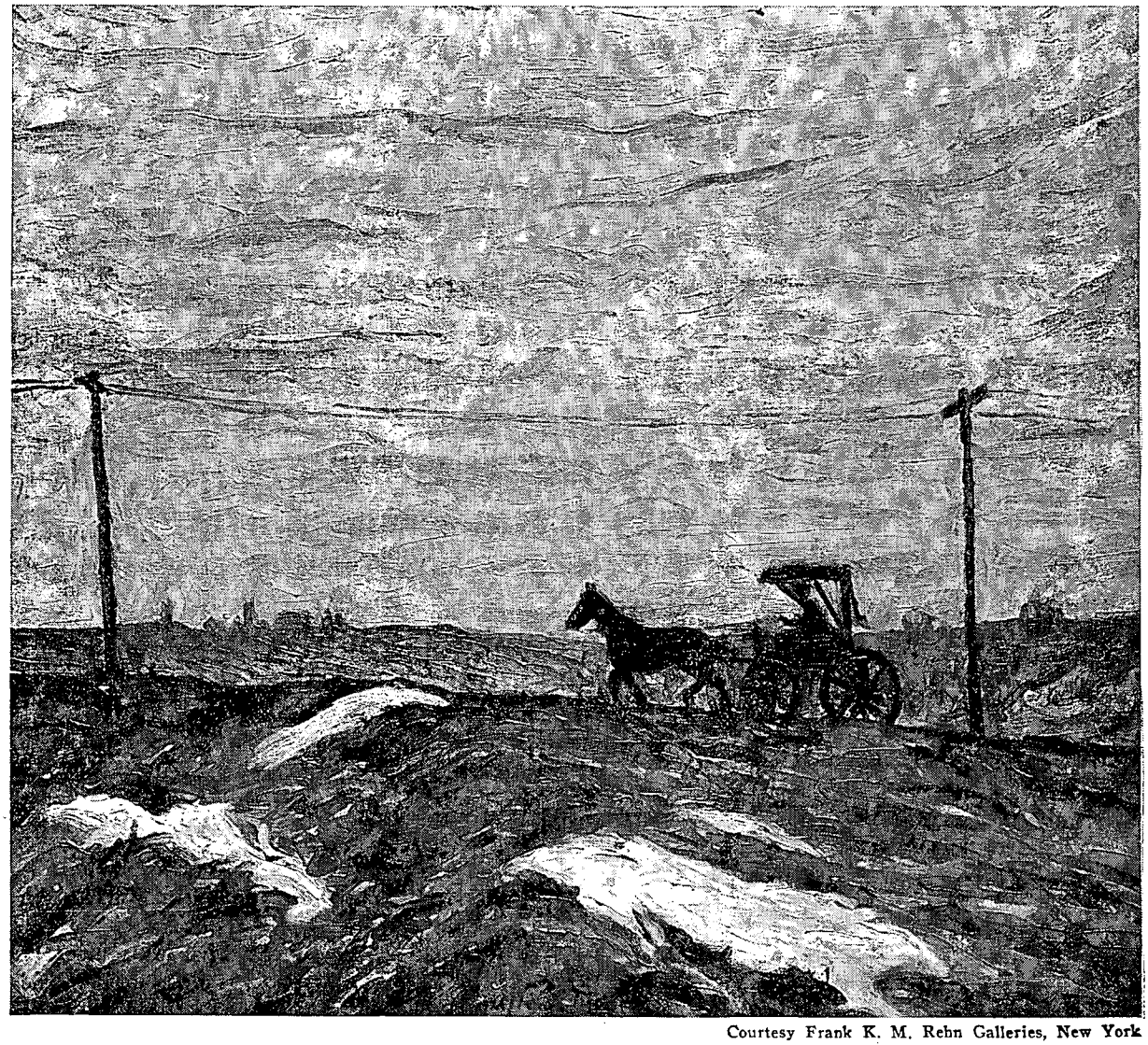

Courtesy Frank K. M. Rehn Galleries, New York

DR. JOSIAH PITE

By Allen Tucker

ALLEN TUCKER likes to make up convincingly real names for his subjects and we suspect that this painting is his tribute, not to any one man, but to a memory of the solitary doctor's buggy jogging through mud and mire. In all but the most remote corners of the world the lone practitioner, with his worn black bag, is passing. Automobiles and hard roads are symbols of the new era for doctor and patient, new not only in transportation but in the quality of medical care itself. This has become not the crushing responsibility of one man, but subject for the skill of many men equipped with delicate and exact apparatus, with better medicines and specialized skill and knowledge. Increasingly the scene of illness is not the home, overburdened and perplexed by conditions it is ill-equipped to meet, but the hospital. What this evolution must mean in cost and organization is still a subject for earnest study; that it must not mean the loss of the spirit of a Dr. Josiah Pite doctors and patients alike will agree.

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An Economist Audits His Costs

By WALTON HAMILTON

Drawings by Gerta Ries

A SHORT time ago, in the course of a very general conversation, I casually inquired of my favorite physician, "By the by, how are those investments coming along which you made with your savings?" A bit deliberately he replied, "Well, they haven't as yet yielded a competence upon which I can retire."

Here, almost in its easiest terms, is the problem of the cost of medical care. In a single year, such as comes now and then to every family, the savings of many moons were assigned, deeded, and delivered over to a physician, to specialists, to hospitals, to the functionaries and factotums of the get-well industry. We are lucky to have the money—or were they lucky that we had it? The bills were far more than we could afford, and in one way or another the costs remained for years to come. Yet the hospitals were not paying expenses; the specialists were thriving, but not like investment bankers; and the physician who did the larger task and carried all the responsibility was not flourishing as the green bay tree.

He was a surgeon of quality and a good all-around medical man. He was for years our family physician, if one who keeps up with the tricks of his trade can be called by so old-fashioned a name. He had spent years in mastering his art; a recognition of his competence had not come until he was well in his forties; his income was far smaller than a business man gets for the use of far commoner gifts. He did not exact of us an extravagant toll; his rate of charges was reasonable; many an item of service escaped enumeration in the account; and with it all there was an insight, a concern, and a devotion which money cannot buy. He was not over-paid; we had to have his services and yet could not afford them.

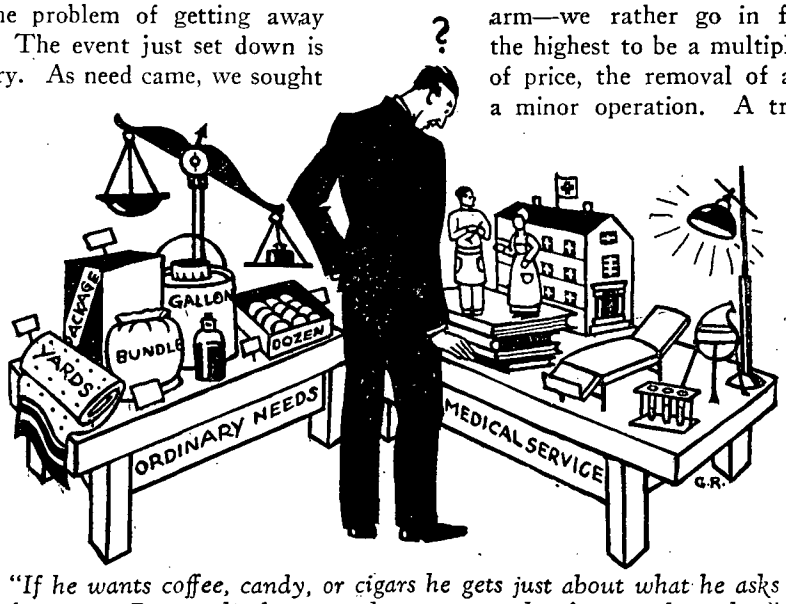
But even this makes the problem of getting away from sickness over-simple. The event just set down is a late chapter in a long story. As need came, we sought medical aid in a town of five thousand in which we were living, in cities of fifty and one hundred thousand nearby, and in a large metropolis. At the time, we had little acquaintance in the personnel of medicine; but we did take the bother to examine such evidence as was to be had and to assure ourselves of formal competence. The physicians we consulted were graduates of the best medical schools; they were reputed to be persons of exceptional skill; one and all they were among the orthodox of the orthodox.

A local light said "nerves," and a greater luminary "stomach trouble;" it turned out to be a diseased gall bladder. An experienced practitioner prescribed rich milk; the head of his division in a great hospital added cod liver oil; a pediatrician of note continued the treatment with forced feeding while the child dwindled. Yet a simple laboratory test, a matter of common knowledge within the craft, would have shown an inability to digest fats. Later, a competent specialist, who has since won a repute he did not then possess, easily discovered the source of trouble and quickly checked the malady; but neither easily nor quickly could he repair the damage caused by "repeated insults to the child's feeding."

AN "ear, nose and throat" man, amazingly skilled in the use of the knife, found an abscess in a child's ear and opened it; a few days later the other ear had to be opened; again, the first, and so on until six incisions had been made. Then, as he reported it, "I made up my mind right then and there that there was a cause. So I looked down her throat and found diseased adenoids, and out they must come." Out they came, the ears quit misbehaving, and the over-diligent specialist made no charge for the sixth incision.

This business of shopping around may have been an education; but it can hardly be described as either a pleasant or a costless adventure. Eventually, of course, men were found who knew the doctor's trade; but they had to contend with something more than the original trouble.

In the same chapter of experience, costs proved quite as puzzling. To one whose job it is to wonder "how prices get that way," items lifted from doctors' bills are a fascinating study. The fees charged for setting a broken arm—we rather go in for this—vary enough for the highest to be a multiple of the lowest. In terms of price, the removal of an appendix is a major or a minor operation. A trio of physicians make the same charge per visit; each has his way of counting up the total, and no one of the three is in the arithmetic. Such differences defy explanation in terms of quality of service, personal repute, or local custom. My list includes extravagant payments to bunglers, reasonable fees to competent physicians, merely nominal charges for sickness of long duration, and services rendered without compensa-



"If he wants coffee, candy, or cigars he gets just about what he asks for. . . . But medical service bears no mark of assured quality"

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tion by men at the head of the profession. In the variety, whatever be your standard, there was payment, over-payment, and under-payment for aid in time of trouble, for no service rendered, for helping sickness along, for clearing up what a fellow physician had caused or complicated.

An experience of a single family is only that and nothing more; and all of this, of course, is conclusive of nothing. It can be supported—not in detail, for the variety is almost endless—but in substance, by the experiences of many acquaintances. One must avoid that treacherous word "therefore," and this is not the place for its use. But even this personal record teems with questions. It makes pertinent and insistent the question of whether, as things are now arranged, the ordinary family can with intelligence and with reasonable prospects of success supply itself with medical service?

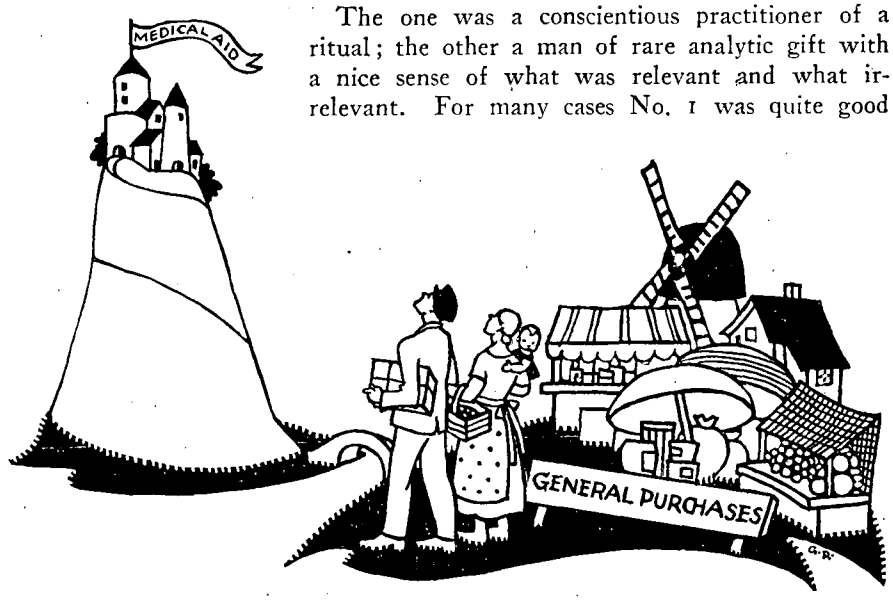
AT first sight there seems to be nothing unique in the task of obtaining and using medical service. The man in need does the customary thing: he goes forth to find it. He takes his demand to market, inspects wares, selects what he wants, pays the price, and takes the purchase home. This resort to buying is fairly well understood in this free land of ours. You and I and everyone has learned something of the knack of purchasing bread and potatoes, shoes and symphony concerts, automobiles and houses and investments. Yet, in the general run of household purchases, medical aid is a thing apart. The service sought is quite unusual; the market is not like other markets; the price does not seem to behave as a good price should; the maxims about how to buy do not seem to apply. The demand is for a necessity; a failure in supply may have the most serious consequences. Yet real hazards attend purchase in the open market.

The average patient cannot tell in advance just what he wants. He takes a vague and indefinite demand to market. He is nearly always an indifferent and very often a sorry judge of the quality of the service he seeks. If he wants coffee, candy, or cigars; if his heart yearns for dancing, preaching, or faking, he gets just about what he asks for. In spite of the devices of salesmanship, he gets something that will do—or at least will do no great harm. And if at first he doesn't succeed, in time he is always ready to try again. But medical service is not all of a kind; it bears no mark of assured quality; there is no test of worth which the purchaser can apply. A license to practice is not a certificate of positive ability; at best it is only a guarantee against gross ignorance and incapacity. For everyday aches and pains the patient may by ordinary diligence assure himself of modest competence. But, for the most part he must buy, even without sample, a highly unstandardized service.

But, even if colds and tummy-aches yield to routine, the serious ailments do not. And whether casual or serious, you can never always tell. The human animal of simian vintage is fearfully and wonderfully made, as psalmists, showmen and neurologists have discovered. Anatomy, physiology, *materia medica,* and the little yet known of healing are all intricate affairs. In attempting to get at something a bit ideopathetic, the run-of-mine medico can muss up his bundle of tricks without half trying. As in statistics, law, and baseball, so also in medicine, it is easy enough to find persons skilled in the uses of their dodges and devices; it is hard to discover individuals who not only know what to do but when to do it.

If something serious is amiss, the demand is for the services of one who can accurately diagnose as well as adequately treat. Not long ago a distinguished jurist was recounting a personal experience: "Well, you see, I really know nothing of physiology or of medicine; it quickly became apparent that he knew nothing about evidence. So, between us, we didn't get very far." A physician recently remarked of a brother in the craft: "Yes, I know. He doesn't put his patients through all the tests, and I wouldn't call him thorough. But he has hit it where I have failed many a time. So how the hell can I tell him how it ought to be done?"

The one was a conscientious practitioner of a ritual; the other a man of rare analytic gift with a nice sense of what was relevant and what irrelevant. For many cases No. 1 was quite good enough; for the baffling problem No. 2 was indispensable. Yet the average patient would never sense the difference; nor is there much to help him. There is no book where particular competences are written down; ability is no more in accord with reputation than it is in law, politics, social work, or preaching; and doctors of medicine are a bit tongue-tied about their brethren until you come to know them—and don't need their knowledge. A wonderful surgical operation that the other fellow ought to have is a luxury few of us can afford; an extraordinary treatment for a quite different ill is a poor substitute for a skillful diagnosis. There is medical service and medical service; yet the bulk of it is bought with little regard to its grade, quality, or character.



"In the general run of household purchases, medical aid is a thing apart . . . the maxims about how to buy do not seem to apply"

It follows that, in purchasing medical aid, quantity is a matter of great bother. In other than the get-well market, goods are neatly done up and there are ways of measuring them. One purchases pkgs. of breakfast food, lbs. of nails, yds. of cloth, bbls. of sugar, and gals. of gasoline; one buys the services of bell-hops, cooks, carpenters, musicians, and architects, with a fairly exact notion of what he will get. But at the moment of purchase, one cannot tell how much

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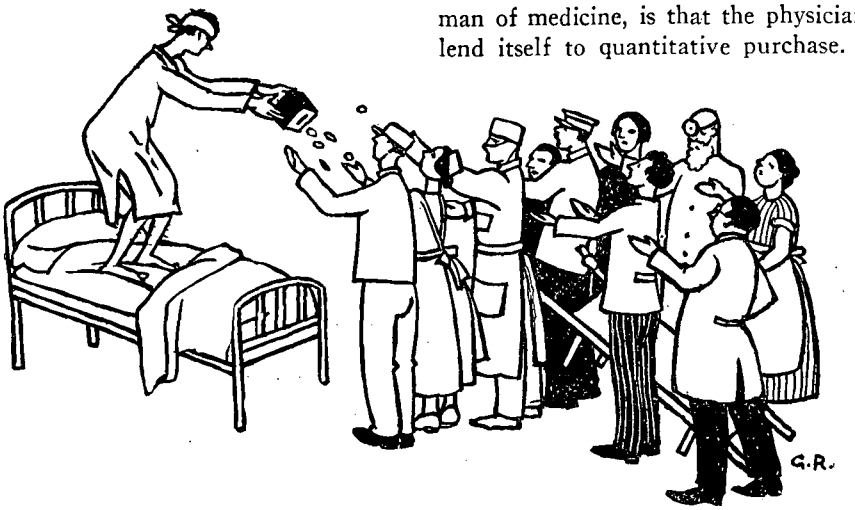
medical aid he will take. A single service may be a single service or the first term of a series that stretches away indefinitely; it may be quite sufficient in itself or may entail the use of the supplementary services of many specialists. There are, to be sure, cases in which we know in advance what we are in for; but far too often the initial act of purchase is the starting of an open account in which our entries are all outgo.

Nor is the price to be paid for the service free from all hazards. Of late we hardly expect prices to obey the laws of price; but even among lawless prices, that for medical service is a bit queer. In very learned books and in the courts of law, price is still regarded as a part of "a contract, arrived at by a process of bargaining between two parties equally interested and equally able to determine its mutually satisfactory terms." In the here and now of the practice of medicine there is no such ideal process of agreement. The would-be-patient is hardly competent to judge what the service ought to be worth; his moment of need is hardly the occasion for the exercise of his bargaining skill; he has no adequate protection against additional services; he is usually diffident and loth to ask questions in advance. So the physician, appearing in the double role of interested party and arbiter, comes to fix his own fees. There are, of course, many understandings; but generally the patient is committed to the bargain without knowing what sum he is to pay.



"The savings of many moons were delivered over to the . . . functionaries and factotums of the get-well industry"

In the delicate task of fixing a just price the physician has little to guide him. If his charges are above those customary, the burden of proof is upon him. If his exactions become notorious, he will drive patients away. If he departs too far and too often from the schedule fixed by the local medical association, where there is one, he may get into trouble with his brethren. The "market" hardly tells him what to charge, as it tells the cotton-grower and the coal-operator; there is no regulatory commission, as there is for the charges of railways and public utilities; there is no principle, no criterion, no standard which will stand him in stead as a yardstick.

The custom of charging patients in accordance with their abilities to pay has a most praiseworthy end. It seeks to give service to all and to distribute the costs in such a way that they may be most easily borne. If it endows physicians with a right of private taxation, the assumption is that excess charges are to be used in cancelling poor men's doctors' bills. But such a principle is as little of a guide in making out bills as the precept that the laborer is worthy of his hire is a help in fixing actual rates of wages. In practice it opens the door wide to personal judgment; for even physicians may give themselves a bit the better of it, and since they were men before they became doctors, they differ in the quality of their mercy. One tempers his charges with charity, consideration, and loving-kindness; another, perhaps all-unknowingly, converts the principle into charging what the traffic may be made to bear. For single services, fees vary mightily; where there is protracted sickness and continued service, the limits of discretion are very wide. If you want first-hand evidence, don the role of the inquiring reporter, stop the first six physicians you meet, and have them explain the bases of their charges. Or, if you must have a real experience, protest a bill or two, ask for interviews, break through the priestcraft, and collect the explanations. It will be worth a lot more than it costs, especially if you keep your temper, and if the matter of price-making belongs in your shop—it doesn't in theirs.

The plain truth, too frequently overlooked even by the man of medicine, is that the physician's time does not easily lend itself to quantitative purchase. In reality there is no such thing as a unit of medical service. The common ills may possibly yield before the ritual of the technician; but every critical illness, acute or chronic, is a case unto itself. Cases seemingly alike differ in the demands which they impose in time, in energy, in skill, and in responsibility. At the very least a standard method of treatment must be nicely adapted to the changing circumstances of the patient's condition. Nor can the time of one physician be easily measured against that of another. A half hour with a great diagnostician holds more genuine medical service than an eternity of the time of a so-so medico. For that reason the rate of charge has little to do with the size of the bill. A high rate per hour or per visit may go with a small bill; low rates are not infrequently associated with large ones. After all, the payment is not for labor or time; it is for getting the job done so that it will stay done.

BUT eventually—and here's the rub—the bill has to be paid. To almost every family, serious illness brings a financial strain. As such things go at present, a really adequate medical service is a luxury which few can afford. The art of medicine has of late advanced by leaps and bounds, but the trend is towards a network of interlocking services. In most other industries, a new discovery or invention must be made "commercial," or put within the reach of the masses; else it remains a "laboratory product." In medicine, the emphasis has been upon making discoveries rather than in perfecting them. In thrusting upon patients all sorts and kinds of special services, physicians are attempting to put to ordinary use inventions which are still in the stage of laboratory products. The incomes of people generally have not kept pace with bigger and better medical services. For the most part, family incomes are still inadequate; they are still far too close to a bare living to allow much of a surplus to be spent on health.

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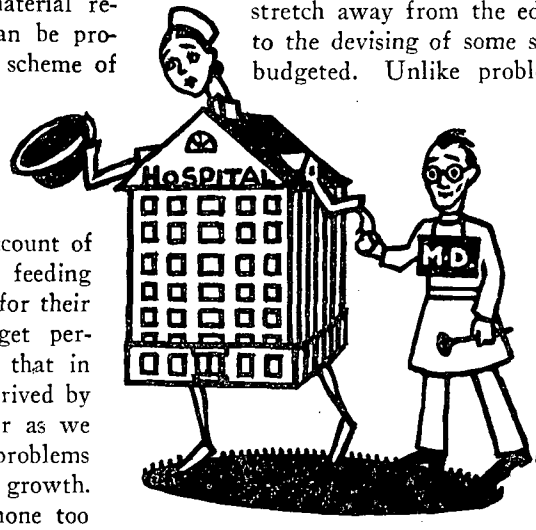
It is quite as serious that doctor's bills do not lend themselves to easy payment. Income is on the whole a fairly regular affair; it gets itself distributed into habitual purchases; it goes to maintain a fixed standard of living. Sickness does not run on schedule; it comes unexpectedly and at irregular intervals; it exacts a heavy financial toll; its costs cannot easily be budgeted. As a result, the process of discharging the debt is expensive and fraught with hazards. A few there are who can promptly write checks and discover no appreciable dwindling of funds. The many in moderate circumstances must take care lest another evil be invited. They can pay, given time enough, by rearranging their purchases; but this may mean making over their habits or rearranging their ways of life. They may live more simply, and perhaps deny to the children the rich exposures essential to their full development. They may make a raid on savings, if they have any, and increase the hazard of dependence in old age. The masses, whose earnings are very meager, must, if they pay at all, pay most in human costs. Many of them who can ill afford the luxury, resort to the loan broker, discharge the debt to the physician, and in high interest charges pay the bill many times over. In any event, the total costs are extravagant in comparison with the incomes physicians receive.

At one time or another almost everyone is visited by sickness or accident. As medicine is currently organized, one must purchase competent aid in the market. How inadequately a great social need is supplied under the prevailing arrangements, this account of the hazards which attend the quest will attest. A few with diligence and care overcome them; a larger number escape through a luck which is never quite absent from human affairs. But, for all of intelligence and luck, the conversion of one's self from the patient-to-be into the patient-that-was is a fine art at which the ordinary man is a blundering amateur.

SO it all comes down to a question. The need for medical service is abiding and insistent. The art of medicine is advancing. Out of the human and material resources at hand an adequate service can be produced. The problem is to hit upon a scheme of arrangements under which need and supply are brought together in the easiest, least hazardous, and most economic way.

Some day a person is going to make himself immortal by setting down an account of how the great social functions such as feeding the people, keeping them housed, caring for their savings, and amusing them actually get performed. It will be revealed, I think, that in no case has an orderly scheme been contrived by conscious planning; that such an answer as we have managed to get to any of these problems has come by the disorderly way of growth. And so it is with the none too tidy, none too wasteless, none too efficient scheme of arrangements which have emerged for giving the people medical service. It was not laid out to plan and cut to scale. It does not reduce to a minimum the hazards which attend the search of professional aid. It is changing, whether we would have it so or not. Like many another human institution, it is capable of being mended.



"Yet the hospitals were not paying their expenses"

Chaos in Medical Practice

MEDICAL practice is far behind the plans that have been developed in industry and in many other forms of public service. It will require the most searching study of the facts and the application of these facts in the true spirit of the experimenter if we are to develop conditions that will make it possible for physicians to meet their own problems and for a single illness not to become a prolonged handicap to an individual or to a family. . . . Perhaps the medical school is not ready yet to insist on a training in economics, government, political science and history, and the relations of medicine thereto; but unless such training and thinking are soon started the present chaos in medical practice will inevitably make for high charges on the sick and an inadequate return to the physican.—*Ray Lyman Wilbur, M.D.,* The Relationship of Medical Education to the Cost of Medical Care, Journal of the American Medical Association, April 27, 1929.

It is idle to expect to find a perfect solution; for panaceas belong to fairy stories, and as yet a social organization cannot be improvised. But we may consciously set about bettering what we have. The task is no "either-or" affair for the debater, the preacher, or the crusader. It involves no choice between "private practice" and "state medicine"; those ever-changing and ill-defined terms, and the antithesis between them, had best be forgotten. Instead, the call is for a constructive attack upon a big problem which is made up of a multitude of little ones. The demand is for inquirers, for inventors in the organization of medicine. A worker, bent upon the conquest of yellow fever, diabetes, or cancer, does not debate the merits of alternative treatments; he attempts to contrive a technique that will work. In a like way, a multitude of problems concerned with the organization of medicine invite intelligent effort. They stretch away from the education of patients to their needs, to the devising of some scheme which allows changes to be budgeted. Unlike problems must not be confused; each must be specifically faced and must yield its own answer. It is only by an intelligent handling of the many problems which make it up that the larger problem of the cost of medical care is to be speeded towards a solution.

The technology of medicine has advanced; its organization has lagged. The technology has been deliberately contrived; the organization has just grown. The organization needs to borrow a lesson from the technology. The problem of mending our arrangements so that the ordinary man has a real chance at adequate service and at a tolerable cost needs to be attacked in the way in which a disease is attacked. The right answer is that there is no right answer. In the spirit of constructive inquiry we can only seek the rightest answer we can find.

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Patent medicines are easier than exercise and diet but how they cost!

Patients Cry for It

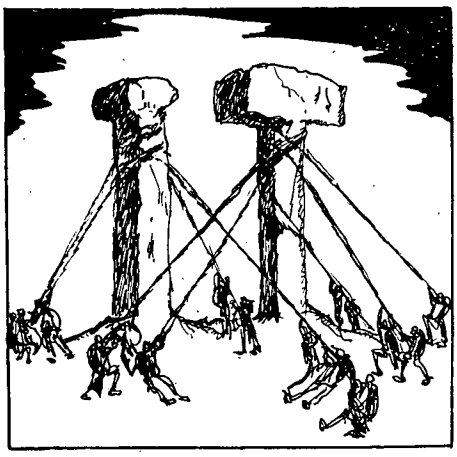
By LOVELL LANGSTROTH, M.D.

Drawings by Hendrik Willem Van Loon

THIS "it" the patients cry for is a will to continue in certain fixed habits of mind, a will to be sick and to be cured in the ancient and commonly accepted manner, a will to be a member of the herd and to follow herd traditions. In this sense it is an inheritance from the past, a relic of the days when disease was due to a demon who could be exorcised. For patients are still bound and satisfied by the idea that complete responsibility for disease lies entirely outside of the self, just as though it was a malevolent power lurking around a corner and ready to attack and destroy.

If you attempt to deny this, just recall your last bilious attack and the particular food you blamed for it. This attitude toward disease is partly justified, for there are many specific diseases against which we have meager, if any, protection. But in a more general way it is not justified, for we are coming to know that many diseases probably depend entirely on our individual or on our group habits of living. This "it" resists the doctor's attempt to change habits of eating, thinking or exercising and has to be patiently broken down by time-consuming explanations and discussions. It is an important item in the cost of medical care.

In relation to food, this attitude is perhaps a little less fixed because of the wide publicity given to some of the newer knowledge. People are more willing to accept regulation of their diet and follow instructions some time after their symptoms are relieved. But tastes are so fixed and the trend toward the group "normal" so marked that sooner or later there is a swing back toward the old. The idea that he must make the effort and deny his will to eat whatever he desires, often becomes intolerable to the patient and he then pursues again the old and more expensive method. If we could just put over the important relationship between our food and our heart muscle, our blood pressure, our joints and our digestion, we would relieve much suffering, diminish the drug bill, cut the cost of medical care and perhaps actually prevent the development of much disease.



Conflict between divergent tendencies

In relation to thinking, the modern doctor finds "it" the greatest possible resistance. For only in the last decade has there been any real understanding of the psychic bases of nervousness and of its frequent connection with physical symptoms. Conflict between divergent unconscious tendencies of the will may cause fatigue, exhaustion, dizziness, fainting attacks, pallor, sweating, palpitation, indigestion or pain in various parts of the body. It may thus interfere with eating and sleeping, with exercising in the fresh air and sunshine, and so indirectly result in lowered resistance to infections, in head colds, sinus infections and what not.

THE relationship is not easy to trace, even by the doctor. He may try to resolve the conflict. But patients are particularly sensitive in this respect and would rather put the responsibility on some outside agent than shoulder it themselves. They resort to other doctors, to various diets, rest cures, hospitals, operations and trained nurses, they lose their time and their chance for happiness in life, they burden their family and their friends with their symptoms, they spend a great deal of money. Reduction of this particular item in the cost of medical care must come by a more careful study of the newer psychological methods of treatment, by an active campaign to put over information about this kind of sickness.

In relation to exercise, there is another resistance to overcome. Many consider health as something with which they should be born, which just goes on existing. They are amazed in middle life to find it in a precarious condition, they are loth to attribute their indigestion or sleeplessness to any omission on their part. Health is like a bank account. It doesn't automatically replenish itself. Checks cannot be drawn continually without occasional deposits. And one of these deposits must take the form of pleasurable, active exercise out-of-doors. One may enter an active physical game with a clouded mind and emerge in a half hour as though the slate had been wiped clean. This sort of exercise affords a release from the previous frustrations of business or professional work, a balancing satisfaction of the will, reassociation of the will and the muscles. It speeds up com-

We resort to many and various diets

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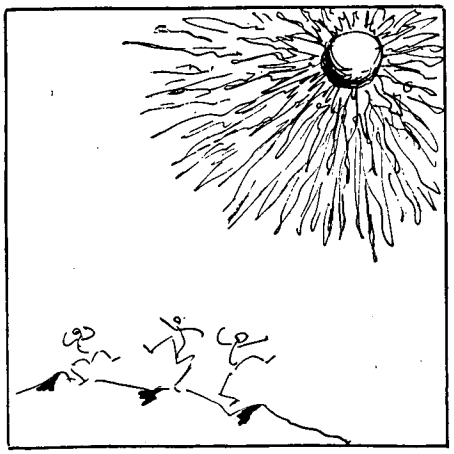
bustion, increases the circulation in organs ordinarily passive and maintains the resiliency of the circulatory apparatus. Many have discovered the benefits by themselves. Others have to be convinced. They offer a resistance to any change in their habits. A woman will often say: "But I exercise enough in doing my housework." True, but few find this a satisfaction of the will. On the contrary, it is often merely another frustration.

After years of inactivity many are totally unprepared for vigorous exercise and should first be gradually trained. Such people may get heart attacks from too sudden and violent effort and thenceforth desist from any effort. Some have always been unprepared for physical effort because of bad posture acquired in childhood. The correction of postural defects takes time, patience and skilled direction, but the effort expended is insignificant when compared with the pain and disability which thus may be relieved. Posture patients may offer special resistance to this approach because their physical defects are often accompanied by an inability of the will to make the necessary effort. The reconstruction must be psychic as well as physical.

Exercise, however, is usually a cheap medicine. It doesn't come in bottles. It doesn't have the dignity of electrical apparatus, or colonic lavage, or white-gowned office attendants, or mahogany desks. But when used intelligently by the physician and patient it does tend to cut a lot of waste motion out of medical practice and above all to reduce the cost of medical care.

In relation to sunshine there is perhaps less resistance to overcome. Pediatricians have insisted it was beneficial—adults have tried it and say "it satisfies." It is now used effectively in this country for arthritis and in Switzerland for tuberculosis of the bones and joints. There is little doubt that a large proportion of winter colds and coughs and sinus infections could be entirely prevented by regulated exposure of the naked body to sunshine during the summer. The protection might be increased even in winter by more fresh cold air and less steam heat, by more dining in and less dining out, by more sleep and less bridge. But this again would mean irksome restrictions, being different from someone else, even "queer." It is easier to look for a sunlamp than for sunshine, to spend the summer rushing around Europe than resting and exercising in the sun. But in January the nose specialist exacts the penalty. He certainly runs up the cost of medical care.



Patients find that sunshine satisfies

It is of course obvious that there is a tendency to over-emphasize the favorable effects of food and sunshine, of psychology and exercise. Psychologists purport to reveal the secrets of success through courses of lectures, "specialists" prescribe what to eat by mail, athletic instructors promise to restore the "old pep and vigor." And not infrequently they hit the mark even though they know nothing of disease. But when these methods are used as a cure for illness they should be prescribed by the doctor.

I get enough exercise at my desk

On the other hand, there is the so-called scientific attitude which refuses to acknowledge a thing may be of benefit unless it fits the scientific mind. It should be remembered that science is built up on the observation of phenomena and that its laws are an attempt to interpret these phenomena in such abstract terms as will fit all the observed facts. Science is in a continual state of flux because of the discovery of new phenomena which do not fit the old formulae and necessitates their revision. What appears scientific today may be nonsense in a few years. The medical journals are filled with scientific material which will soon be scrapped. The greatest scientific spirits recognize the fallibility of science and are always ready to revise their premises.

BETWEEN these two extremes lies a common-sense view. It recognizes that our living habits are perhaps the most important items in our health, that fresh fruit, fresh milk, fresh eggs, fresh vegetabes, fresh green salads and a moderate amount of meat should form the basis of our diet, that most nervousness is due to unconscious conflict which can now be successfully treated, that physical training is a necessary part of existence and that sunshine protects against infections. It keeps down the cost of medical care by maintaining good health. But it recognizes that x-ray machines, metabolism apparatus, and electrocardiographs may be of incalculable value at times, that honest surgery often cures disease and saves lives.

The modern doctor is working toward the elimination of his own species, though this consummation may be expected in the millenium just as the tangent touches the straight line in infinity. There is a growing expectation on his part that the layman will come to accept a greater responsibility for his own individual health. But this is answered on the part of the layman by a growing insistence that the doctor will wisely sift the scientific wheat from the chaff.

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A Professor Prices Babies

What 540 New Citizens Cost in Columbus

By MARY LOUISE MARK

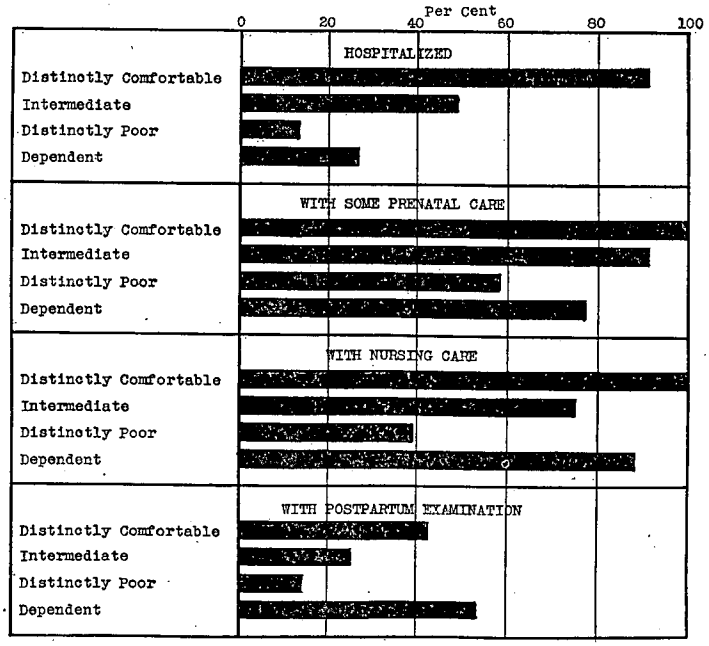
"MY parents paid the doctor five dollars when I was born and gave him his breakfast and fed his horse; when my baby came we paid the doctor fifty dollars, and the hospital bill was sixty-five dollars. No wonder families now-a-days are small. Only rich people can afford children." Such is the comparison heard again and again in varying tones of protest from parents of young children. For in a single generation new standards of medical care have developed and both the medical services and their costs have multiplied until a comparison between the expenditures of consecutive generations has become a startling contrast.

Although birth is an integral part of family life the statistical studies of family expenditures have never included its cost. Nor has this inevitable expenditure of the normal family been reckoned in the costs of a "minimum standard of health and decency." It is only from the scattering experiences of young parents intelligent and vigorous enough to voice their unhappiness, or from the case records of families that cannot meet the crisis of birth without recourse to community help that we have had any specific data relating to costs. What of the experience of the inarticulate and independent poor and near-poor that form so large a proportion of the families of every community? Are they silent because they are satisfied? Just what goods and services are involved in the medical care of mothers and babies of the various economic levels? What do the families pay for these? Are they getting their money's worth? Such inquiries can be answered only by community-wide study.

Early in 1928 a group of students at Ohio State University attempted to answer these questions for the city of Columbus. All birth certificates of legitimate babies born within given dates were copied and visits were made to the parents and later to physicians, hospitals, and social agencies in order to obtain a complete and reliable account of the cost of all goods and services involved in the nine months of the baby's prenatal life and the one month of normal convalescence and adjustment following the birth. A 10 per cent sample of all the babies born in a year was thus studied. The results are probably fairly representative of any city in which the general level of prices is comparatively low and the population predominantly native white.

Columbus has grown to a city of 300,000 chiefly because country people move to town. The population is largely native white middle class. Reproducing couples are as a group young and rather poor. Not one family in ten is well-to-do while four in ten are distinctly poor or even to some degree dependent upon the community for help in emergencies. The majority, however, belong to that group of people important in every community, who manage to maintain some of the economic traditions of their families and to enjoy some of the modern conventional modes of living without falling to the level of distinct poverty or attaining a level of real comfort. They find life a problem of "getting along" and a birth an emergency to be met with what skill they may command.

HOW much does a baby cost? "The answer," says the disgruntled parent, "is, 'how much have you?'" Columbus parents paid for these 540 babies, the "run of the mine" of a city's natural increase, all the way from $692 to nothing at all. In each of the three population groups, at least one baby had parents able to pass this strait in their affairs without cost to themselves. The highest expenditures, however, varied considerably, being $692 for the native whites, $407 for the foreign and mixed whites, and only $180 for the Negro group. The 540 babies cost on an average $110. The babies of parents in distinctly comfortable circumstances (earnings of $3,000 or more) cost $270; those born to parents of intermediate status (earnings of $1,200 to $3,000) cost $129; those born to the very poor (earnings under $1,200) cost on an average only $64; and those whose parents were dependent upon the health or social agencies of the community during this pregnancy or within recent date cost their families the small average sum of $27.



Per cent of mothers of each economic condition reporting specified kinds of medical care

A very considerable proportion of this expenditure was for doctors' and nurses' fees and hospital charges. Of the $110 spent for the "average" baby, $82, or three-fourths, was consumed by medical costs; $23, or about 21 per cent, was spent for

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the babies' outfits; and the remaining $5, or 4 per cent, was used in meeting miscellaneous expenses, chiefly extra household service. Not only are medical costs three times as great as all other costs combined, they are also much less under the control of the family because these needs of the mother and baby at the crisis of birth are less predictable than are other items. And yet in all three racial groups not only the amounts but the proportions spent for medical services tend to decrease with lowered economic status. The explanation lies in the fact that poor families skimp attention and doctors adjust fees.

THE averages tell the story. Parents in easy circumstances paid out for medical care $215, those of intermediate status spent $97, the very poor spent $46, and the dependent $17, or to put it another way, the distinctly comfortable spent on an average more than twelve times as much as the dependent, more than four times as much as those who were not well-to-do yet not distinctly poor. That parents of the various racial backgrounds will purchase medical care if they have the money is indicated by the average amounts spent by each of the three population groups:

Economic status	Native white	Foreign and mixed white	Negro
Distinctly comfortable	$226	$188	$—
Intermediate	99	97	59
Distinctly poor	50	49	34
Dependent	27	24	11
Total	92	69	26

Obstetrics in Columbus is "the general practitioner's specialty." Midwives are eliminated by strict legal regulation; highly trained specialists are few. Of the 177 physicians in charge of the 540 births, only 17 are registered in the Directory of the American Medical Association as obstetricians or as specially interested in this field of medicine.

Mothers without funds for the services of a doctor may have at no charge the thorough and systematic routine of antepartum and postpartum care of the clinic of the Ohio State University Hospital accompanied by the home care and instruction of the District Nursing Association. All home deliveries of clinical cases are conducted by senior medical students. All first or difficult births are hospitalized and supervised or conducted by members of the staff. Clinical care is popular among the Negroes, for 38 of the 106 Negro mothers as contrasted with 17 of the 431 white mothers were regular clinical cases.

ALTHOUGH physicians are criticized for high medical costs, their share of the medical bill is not exorbitant. Of the $82 average for all medical costs, only $47, or 57 per cent, was paid to the doctor, while $26, or 32 per cent, was spent for hospital care and $8, or somewhat less than 10 per cent, was spent for nursing care. The other dollar went for small miscellaneous expenses, chiefly medicine and dressings. The proportionate amounts of the medical bill spent for physicians' services vary from less than one-half in families of means to more than three-fourths in poor and dependent families. The characteristic fees paid by white families to their physicians are $100 by the distinctly comfortable, $50 by those of intermediate status, $35 by the distinctly poor, and $25 or less by the dependent. Many physicians declare that they handle their obstetrical cases at lower rates than their other practice and that they can afford neither to lower their fees nor to increase very much their attention to their cases. When it is recalled that they, like other business men, have losses from bad debts these fees seem very reasonable.

With the exception of clinical and other scattering cases it may be said that in medical care as in most other commodities, people get just about what they pay for. The accompanying chart shows how in some of its more important aspects medical care varies with the bill. The one way out is to accept the status of dependency. In all the details of medical care the very poor compare unfavorably with the other economic groups. They seek the doctor later in pregnancy, make fewer visits, have fewer and less thorough physical examinations and laboratory tests, and have special operative care and treatment only one-third as frequently as the mothers and babies in better circumstances. The very poor economize in nursing care. Twelve per cent have the nursing service of the Metropolitan or John Hancock Life Insurance Companies, 8 per cent employ district nurses, and 8 per cent private nurses. Cases with hospital nursing bring the total per cent with nursing care up to 39 per cent of this group, as contrasted with 88 per cent of the dependent mothers, 75 per cent of those of intermediate status, and 100 per cent of those in comfortable circumstances.

PHYSICIANS usually state that they make a flat charge for the delivery regardless of the amount of prenatal care at the office. In practice, however, the average number of prenatal visits varies directly with the amount of the fee. Of the native whites:

Those paying	$20 or	$25	averaged	2.8 visits
Those paying	$30 or	$35	averaged	4.2 visits
Those paying	$50		averaged	5.8 visits
Those paying	$75		averaged	7.1 visits
Those paying	$100		averaged	8.7 visits
Those paying	$125 or	$150	averaged	10.3 visits

Forty, or nearly one-fourth of the very poor mothers, many of whom are foreign born, had no medical care except at the delivery. In some of these cases the doctors collected their fees on the occasion of the delivery and made no postpartum calls.

Some of the poor are definitely antagonistic to the physician, not because he neglects them but because they think he charges too much. Some of the physicians, on the other hand, call their patients ignorant and let it go at that. How are these mothers to become aware of modern standards of health and safety if not by their one medical contact? A poor mother thus describes her only prenatal visit: "He told me what to do and gave me some pills and I didn't have to go back no more."

Only the well-to-do and the dependent in Columbus have medical care at childbirth approximating modern standards. The very poor and the lower range of those classified as intermediate have far from satisfactory care. Although ignorance and carelessness are contributing causes, the chief difficulty is lack of funds. The more intelligent of the parents in close circumstances are the chief sufferers because they are conscious of the risks involved for both mothers and babies. As long, however, as the present gap between the cost of standard services and the poor man's purse exists, just so long will mothers who will not accept charity choose the risks of slight care rather than the certainty of staggering bills.

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CONSULTATION OF DOCTORS

By the French painter and engraver Boilly (1761-1845), *whom Elie Faure calls "a spinner of tales of every-day life"*

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A Merchant Looks at Medicine

By EDWARD A. FILENE

HEALING is a science. Some may insist that it is also an art, but the average modern doctor will accept the statement with serious reservations. There are too many "artists," he is likely to point out, assuming to heal the sick, not according to any scientific diagnosis nor any understanding of actual therapeutics, but according to the latest hunch of their own artistic temperaments. I wish to be excluded, then, from the horde of cheerful ignoramuses who stand ready at all times to tell the practitioners of medical science just what is wrong with their profession.

But healing, whether a mere art or a science, is also a business; and a business man need not apologize for looking that business over and expressing some doubts, if he develops any, as to its efficiency.

It seems to me that, while the *science* of healing has been making tremendous strides of late, the *business* of healing has been lagging woefully behind. I have two major criticisms. In the first place, I do not believe that doctors, generally, are receiving anything like sufficient pay for their services. In the second place, I think the public, as a rule, is paying altogether too much for the services which it gets. Readers who have not studied business organization may think that these criticisms are mutually exclusive. But those who have studied our business system will recognize that these two ailments very commonly go together. The high-price industries, as a rule, are the unprofitable industries. It is in industries like the manufacture of motor cars, in which first attention is paid to bringing down the price, that the greatest profits are realized.

I am not going to propose, however, that doctors undertake to speed up their operations. I shall not suggest that patients be conveyed to them on a moving belt, while each surgeon makes a particular thrust with the particular instrument which he is trained to handle best. I do claim that the fundamental truths of business may be applied to every business, including the business of healing.

I do not criticise the medical profession for not understanding the principles of modern business. Our modern business leaders themselves do not understand them yet. But they must work according to those principles, for the simple reason that those who do not do so must soon cease to be our leaders. I do not claim to understand all the principles of business: anyone who would dare make such a claim would not be worth a hearing. It is only the fundamentalists in business, like the fundamentalists in theology, who know everything; and most of what they know is demonstrably not so. We are in the middle of the greatest social revolution in history. A whole new world is coming into existence; and anyone who already knows all there is to know about that world and its relationships, is either God, or else he thinks he is. Readers must use their own judgment as to how to classify him.

The most we can hope for, in the present business and social revolution, is to attain a scientific attitude towards its events. That is the attitude of a learner; the attitude of our leading medical men toward the events of medical science.

WHILE I am not censuring the medical profession, then, I wish to call their attention to a few of the discoveries which the students of business have made, and see if they may not be applied to the business of medicine. These discoveries may not advance the science of healing much; but they should advance the business of healing; and that, after all, is what most of us are interested in. It is not enough for the average sufferer from disease today to know that his disease is curable. What he wants to know is that there is a practical chance of his being cured. Information that there is some wonderful healer over in Europe, who could cure him, would not help the average American workingman. He cannot hire that particular healer to come over here. His only chance of being helped by what that healer knows is through that healer's knowledge being brought to him through the organization of the healing business. In the last analysis, this is a problem of distribution.

A generation or two ago, we could not see this business of the distribution of knowledge, as plainly as we may see it today. For we supposed, in those days, and it was quite natural that we should suppose, that it was possible for men to master the profession and to learn about all that the whole profession knew. We know now that that cannot be done. We may honor the old general practitioner. He was a hero in the battle for the common good. Nevertheless, he was, and had to be, very much of a free lance; and the most that he could do for a patient generally, was to give that patient the benefit of what he had learned in college and later in the school of his own practical experience.

We cannot depend upon general practitioners now because it is impossible that anyone should practice all the knowledge which the medical profession throughout the world has brought to light. The function of the

The New Order in Medicine

THE profession of medicine now faces a great new responsibility forced upon it by the rapid evolution of a new economic order. The tradition of the man of medicine has been to make his discoveries available to science and to every doctor. Now he faces the necessity of working out a program which will make his discoveries actually available to all. We have the facts, we have the trained physicians and nurses, but we have not as yet been able to meet the ideal of seeing that each member of civilized society obtains that advantage which is possible to him if he can get his share from the great pool of scientific medicine. To make medicine fit in with the other social forces so that its distribution will be uniform, is vital in this age of science and democracy. —*Ray Lyman Wilbur, M.D.*, in an address at the University of Virginia, October 22, 1929.

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practitioner today must be less and less a matter of applying his own superior wisdom to the needs of the patient, and more and more a matter of placing at the service of the patient the knowledge and skill of the whole medical profession.

One does not have to know anything about medicine to know this. The principle applies to all scientific professions. The same principle applies to education in general. It was not so long ago that boys went to college with the idea of becoming well-read. But no one could possibly become well-read today. There are more good books published in a single season than any grind could master in a lifetime. There isn't a brain in existence which could keep up with 10,000 printing-presses.

There was a time, in very early history, when one could become well-read. The gist of what the world knew might be pretty well covered in a set of books which a sufficiently curious and industrious mind might, within a lifetime, read and understand. But no one could possibly get even the gist of the knowledge which science is digging up in our time. The educated man today, then, cannot hope to be well-read. The educated mind today is the mind which best learns how to *use* the knowledge in existence, particularly those truths which may apply to the thing which he is doing.

The business of healing is hampered, it seems to me, by failure to organize on these incontrovertible truths. It is hampered by the old traditions; particularly by the tradition that a man, by passing certain university examinations, may be equipped to practice medicine.

No layman needs to apologize for declaring that the average doctor in America today does not know how to practice medicine. For the doctors themselves are constantly saying this, more emphatically than they possibly could say it by calling each other frauds. It is a common, everyday experience for the sick to shop around for a cure; and to be told by each successive diagnostician that all other diagnoses were utterly wrong. One doctor may find a heart murmur and treat the patient for that. The next may declare that the trouble is malnutrition; the next that his kidneys are not functioning as they should; the next that he is simply nervous and worried; and the next that the case is obviously one of some glandular deficiency. There may be some truth in what they all say; but this truth is not organized so that the patient can employ it.

Now, this is not good business for the doctors. And it is very bad business for the patients. Such shopping costs money. A woman may waste a lot of time in our store, looking for something she cannot find. But we do not charge her for looking, and doctors necessarily do. The cost of sickness is one of the most tragic taxes on human life today; and the cost is made additionally burdensome by this practice of shopping around among the healers instead of being able to connect at once with the combined resources of the healing profession.

EVERYBODY knows, in his personal experience, of tragedies due to preventable and curable ills, of lives which have been wrecked which could have been saved if the patient had been able to consult an organized medical profession instead of having to shop around without guidance among innumerable doctors. I have known promising and ambitious employes to become unfitted for the work of life, because of protracted sickness in their homes. In the reports of many of our credit unions, it has come out that by far the greatest call for small loans—a demand aggregating a third of all the demands made—has been to cover the emergencies caused by sickness and by doctors' bills. When we remember that credit union work has only begun in America (although it has 25,000 stockholders and assets of $40,000,000), and that the masses of our people in such emergencies are still likely to fall into the hands of loan sharks, we may appreciate what this burden means.

To the credit of the medical profession, be it said that it has worked hard, early and late, to spread the principles of hygiene. The medical profession has shown real nobility in this. It has not wished to profit out of sickness. It has preferred to teach people how to keep well. Unfortunately, that is not enough. It is good as far as it goes, just as the propaganda of the business interests has been good when they have united to spread the gospel of thrift. But there is something lacking in both cases. Neither personal health nor personal saving is a strictly personal matter. People do not and cannot learn to save adequately individually; for saving, as we have recently come to learn, requires harmonious mass action, and there is a vast difference between this mass action and action by each separate individual in the mass.

Mass production does not mean that everybody shall be over-worked; and the maximum service on the part of the medical profession does not mean merely that every doctor shall work as hard as he can. In both cases it means that work shall be co-ordinated, and that this co-ordination shall be effected on the principle of maximum service at a minimum cost to the consumer.

It would not cure our economic ills if everybody should suddenly become very thrifty and very sensible in the handling of his personal finances. Everybody might become as shrewd as David Harum, but everybody could not thus get ahead of everybody else. The masses can advance only as mass action is organized along strictly scientific lines to bring to everybody the greatest possible service at the lowest possible cost.

Now I believe, and I should like to be corrected if I am

Teeter-totter in Middletown

IT begins to be apparent that the profession of medicine, like the occupation of running a drill press or selling real estate in Middletown, swings around the making of money as one of its chief concerns. As a group, Middletown physicians are devoting their energies to building up and maintaining a practice in a highly competitive field. Competition is so keen that even the best doctors in many cases supplement their incomes by putting up their own prescriptions. Meanwhile, one observes the situation of some fifty local doctors spending much time sitting in their offices waiting for patients to come in and proffer the requisite money for treatment, "needing," as one of the ablest of them expressed it in a professional memorandum to a group of associates, "a chance to grow in practice as well as professional attainments," while at the same time 38,000 people, most of whom have some physical defect great or small needing correction, are in only relatively few cases having these defects treated by the best medical skill the city possesses. . . . Neither the physicians nor the people are satisfied with this situation in which medical skill is engaged part of its time in a game of teeter-totter with the city, the institutional devices of "price," "competition," and "professional ethics" being the fence over which the two groups see-saw up and down.—*Middletown, by Robert S. and Helen Merrell Lynd* (Harcourt, Brace and Company).

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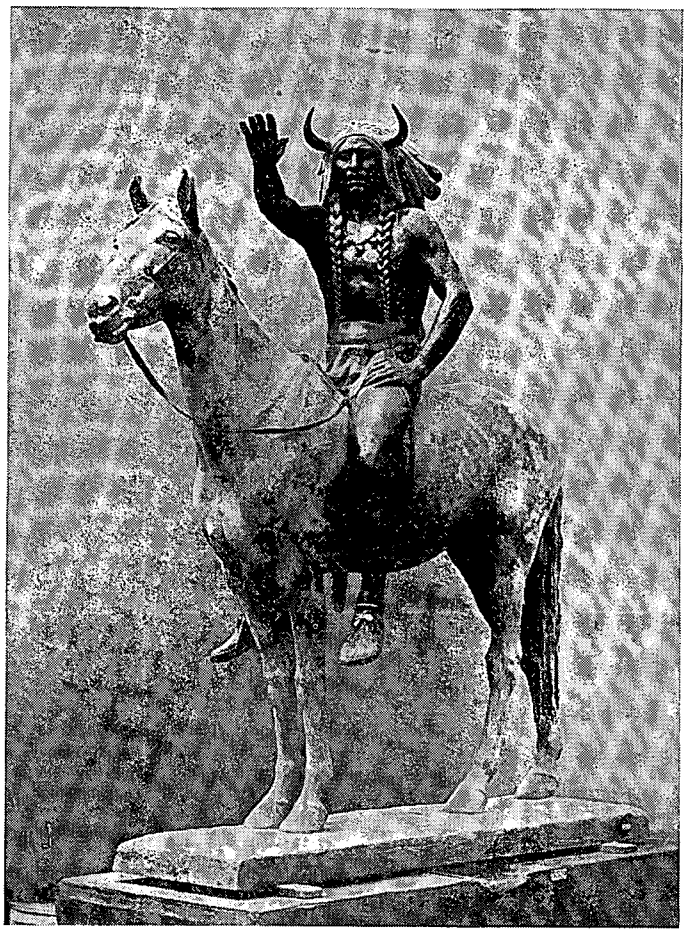
at fault, that ten regular physicians in a modern American community, are likely to know more than one. And if healing is a science, instead of an art (using the word "art" as we employ it in the case of a painter or a sculptor), I believe that ten physicians, combining their resources and their knowledge, could be of far more use to the average patient, than the ten guessing at him individually could possibly be. I do not believe that ten artists can paint a better picture than the best of them could paint alone. Their combined efforts, I fancy, might be even worse than the worst of them would individually produce: and if healing a body is analogous to painting a picture, then none of my suggestions can be considered apropos. But this, I understand, is not the theory of the medical profession. Their theory is, I believe, that healing is a science; and that the advantage of consulting a regular physician instead of resorting to an inspired healer lies in this fact.

Medical traditions, however, seem to a business man to be somewhat out of harmony with this scientific concept. It seems that the profession is not always able to forget that the doctor was once a Medicine Man—a sort of priest who got his knowledge from supernatural sources—and that his holy dictum on the sacred matter of fooling the evil spirits of disease is not to be questioned by any mere customer. The customers might conceivably feel that way about their doctors still, if the doctors themselves were not destroying their faith. The case of the doctors is something like that of the Supreme Court. We laymen were always ready to listen with awe to any mistaken opinion which that court might utter, if a minority of the court itself had not almost uniformly risen to explain to us how mistaken this majority's opinion was.



THE MEDICINE MAN, *by Cyrus E. Dallin*

Most convincing of all tribal wise men is the Indian, whom Mr. Dallin knows from long-ago boyhood days in Utah. This famous statue is in Fairmount Park, Philadelphia

THE highest courts, we have learned, may be wrong, even if their decision be unanimous. And the decision of a group of doctors, merged in one clinic, may be wrong. Nevertheless, an organized health center should be able to give a patient far better service than any individual practitioner would be likely to give him; and even if the service were no better, this organized service would cost the patient much less time and money than he would be bound to spend in purchasing a dozen doses of advice piecemeal.

It may be said that medicine is so organized. Do we not have our hospitals and sanatoriums, as well as organized private clinics in all of our large cities? Yes, we do; and in many of these hospitals, those who have no money may be treated free; which means, of course, that those who are not treated free must pay more for their services than those services are supposed to be worth. Now, this is a good charitable principle, and I see no way of abolishing such charity just now. But it is not a good business principle. It will be well to keep that in mind.

It is not a good business principle for two specific reasons. Unless there is one price to all, a business cannot organize for maximum service. It cannot do so, because it cannot measure its service, and will be constantly tempted, while being good and generous to this and that needy customer, to keep its eye out constantly for every chance to gouge. I, personally, am not particularly injured by the large fees which the medical profession charges those who it considers can afford to pay. But the *medical business is injured* through having to make such distinctions. It is kept from gauging its services scientifically. The healing business, in other words, is defrauded of any workable economic check upon its activities.

The burden of this system bears heaviest upon neither the wealthy nor the very poor, but upon the average person. It discourages the average person from trying to secure the best of medical attention: and no business which is organized in such a way as to discourage the masses from becoming customers, is on a solid economic basis, no matter how excellent it's scientific attainment may be.

There is another way in which the student of business must criticize the organization of most of the hospitals and health centers today. They do not make a profit. No business which is any good can be organized merely for profit—business must be organized for service—nevertheless, if a business does not make a profit, it has no way of measuring its services. Business should make a profit. The healing business should be profitable. We should find a way, if possible, even to make our hospitals profitable. I think we shall find such a way in the end, but the medical profession alone cannot find it. It will require the co-ordination of all business—the general adoption of mass production methods combined with the reduction of unemployment to a minimum, and the raising of wages to such a standard that practically everybody shall be able to pay for all the services which he needs. But that (*Continued on page* 448)

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The Dying Patient or Doctor's Last Fee
Color print by Rowlandson

Simplified Procedure. Water color by Rowlandson

Vignette by Daumier
From Némésis Médicale

Old Jibes at Doctor's Fees

From a compilation by Dr. Eugen Holländer, Die Karikatur und Satire in der Medizin. Verlag Ferdinand Enke, Stuttgart

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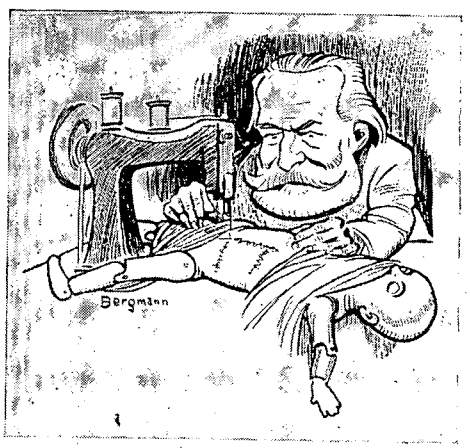
The Doctor. Lithograph by Daumier. "Why do my patients die? I have bled them well, purged them, dosed them. I don't understand it"



The Surgeon
From Lustige Blätter

(And at Doctors)

The X-ray Man
From Lustige Blätter

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Public Health *vs.* Private Practice

By SHIRLEY W. WYNNE, M.D.

THAT is just what it should *not* be—public health *versus* private practice in any tug-of-war fashion. This conception of each side pulling hard against the other is meeting with the condemnation that it deserves. We must learn to speak of public health *and* private practice. For every physician is, and should be, in the last analysis, a public health officer.

What we understand as public health work has undergone a tremendous evolution during the past fifty years, and many of the misunderstandings between the medical profession and the health authorities are due to the readjustments which have been part of this evolution. The work of the New York City Health Department, sixty years ago, embraced little more than the supervision of certain sanitary matters such as drains, privies, plumbing, damp cellars, and the like, the control of smallpox by vaccination and the control of other contagious diseases by quarantine measures. The relation of bacteria to disease had not yet been demonstrated. We realize, accordingly, that much of the work of those days was not and could not be effective. A revolution in health work was effected with the demonstration of the role played by bacteria in disease.

The last two decades have witnessed an astonishing amount of curative work done by health departments. And the relationship of the private practitioner to the public health program has subsequently become an angle of great contention.

Economically speaking, the medical profession stands on uncertain ground. With medical science pausing at the threshold of a new era—the era of preventive medicine—the economic aspect presents no small problem. Medical science will only cross into that new era successfully if it is accompanied by an economic harmony of cooperation.

It is really but within comparatively recent years that physicians have awakened to the realization of an economic crisis in their midst. There has developed the pertinent problem of assuring the patient of moderate means competent private medical services. There has arisen the perplexing problem of how to limit free facilities only to those who cannot afford to pay. There has developed the collateral question of fees in private practice.

On the one hand there is the physician, seeking his legitimate livelihood, no longer content to rest upon the popular and non-remunerative theory that it is the doctor's business to care for the sick but that he has no business to consider it a business! On the other hand, there is the patient of moderate means—willing to pay for the services of a private physician, provided the fee is within the possibilities of a moderate income—yet totally at a loss how to obtain such service without economic disaster to his limited resources. And midway between physician and patient stands the health department—desirous of assisting and cooperating with the private physician, equally desirous of lending a helping hand to those seeking medical assistance, and thoroughly determined to do all in its power to maintain good health in the community. An economic triangle within the realms of the medical profession—with the private physician, the patient and the health department each clamoring for fair play!

MANY doctors have displayed hostility from time to time to certain health department activities, on the economic ground that they were trespassing on the private domain of the medical profession. In New York City—and I believe it is true of most communities in our country—activities of this sort have rarely been established where the private physician could and would supply the necessary service. How are we to silence the cries of "too many free clinics for health grabbers," "too many patients who want their services free" and "too much health department activity trespassing on the legitimate economic domain of the private practitioner"? Only by the willingness of the health department and the private physician to join hands.

The duty of protecting the public health is the particular concern of governmental or official health agencies. While the character of the health protection rendered a community rests to a certain degree with the citizens of that community, it rests to a larger extent with the officials who are charged with these duties. It is the duty of official agencies not only to exercise police authority for

"Your Fight, Too, Fathers and Mothers"

Cartoon by Clive Weed for The New York Evening World, used by the Diphtheria Prevention Commission on posters pasted up in the hallways of thousands of New York tenements and on a flying squadron of healthmobile trucks

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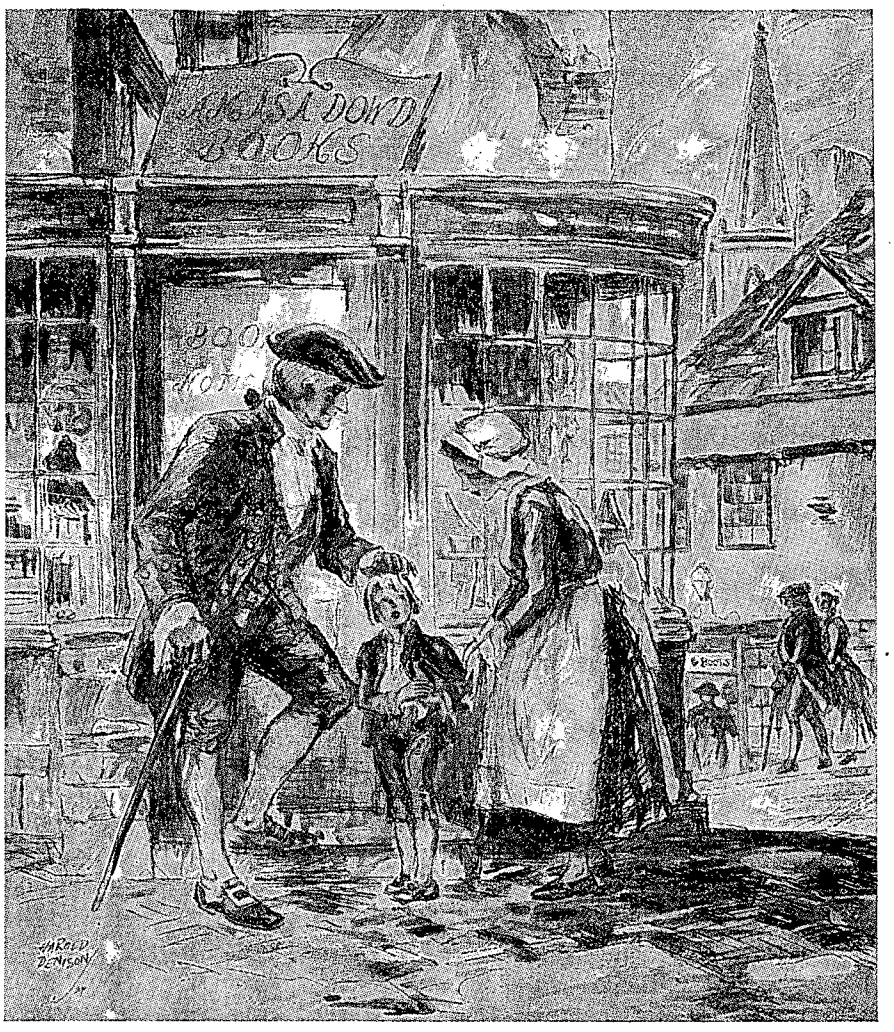
the protection of the public welfare in general but to establish and conduct medical and educational services which the poor require where they are not otherwise provided. In that sense, it is the duty of health departments to maintain clinics for important health needs of individuals economically unable to go to the private doctor.

It has been estimated that 50 per cent—and this is probably a low estimate at that—of the people in the City of New York can afford to purchase their own preventive health service. The doctor should supply the preventive service to those who can pay, the health department or some other official or semi-public agency to those who cannot afford to pay. Admittedly, the free clinics are sometimes patronized by people who are able to afford the services of a private doctor. This problem is difficult to meet. But it is possible to take the majority of these persons away from the free facilities which have been established solely for those who are too poor to pay for medical treatment. The person of moderate means can be brought back to the private practitioner.

The health department is the logical agency to lead the way in educating the medical profession to the type of service demanded. Our experience in New York indicates that if, side by side with the establishment of important health activities, an honest effort is made to have as much of this work done by private physicians as possible, in a relatively short time the medical profession will realize that, far from making inroads on the practice of the private physician, this type of activity results in a considerable increase in their private practice. After all, most people who can afford to pay a modest office fee will prefer to have their children examined and treated by their family physician rather than seek examination and treatment at a public clinic. This back-to-the-private-practitioner movement permits, of course, of no methods of compulsion. We must depend for its success upon an effective combination of cooperation and action. We must depend upon the private physician, the health department and well-conducted public health education.



"Children Were Not Protected from Diphtheria in George Washington's Day"
Illustration loaned by the Irving Trust Company of New York City for a full-page newspaper advertisement used in the New York State campaign to wipe out diphtheria by 1930, in which departments of health and education, medical societies, social and welfare groups have joined hands

As a concrete example of possible cooperation between a health department and private physicians, I offer you the Diphtheria Prevention Commission of the New York City Department of Health. It has been the guiding policy of our diphtheria campaign that insofar as is consistent with the public health, the work of immunizing children should be done by private physicians. We believe it is the responsibility of the doctors of the city to do the actual work of immunizing the children brought to them. We have kept to this policy. As a result of cooperation with private doctors nearly 40 per cent of the 165,265 children immunized since the campaign began have been treated by private physicians.

It has been a guiding policy of our diphtheria campaign to carry on an educational campaign directing people to private doctors to overcome the ethical prohibition against a doctor's beckoning to practice. In every piece of literature, in every spoken address, we have advised that wherever possible the public should go to the family physician for treatment. Circulars signed jointly by the Department of Health and the co-operating county medical societies were distributed to the 12,000 private physicians to be mailed by them to families in their practices with children under ten. Many physicians requested extra copies and in all more than 200,000 were sent out in this intensive cooperative effort.

Our more recent experiment is to suggest a flat fee of six dollars for the three toxin-antitoxin treatments. In co-operation with the Medical Society of the County of New York and the Bronx County Medical Society, 7,225 physicians in the boroughs of Manhattan and the Bronx were asked to set aside a special day each week for the diphtheria treatments, and further to sign a voluntary agreement in which they pledged themselves to charge no more than six dollars for the three simple toxin-antitoxin treatments. We are compiling a list of these physicians and the special conditions under which they will administer toxin-antitoxin in their offices. This list is confidential, of course, to be used by our department, the medical societies, school principals, clinics and wherever else it can be ethically employed. There are already approximately 3,000 physicians, or 41 per cent of

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the total number solicited, who have volunteered agreement.

It is my belief that we are now on the verge of an era of preventive medicine. Twenty-five years from now we should find doctors practicing 90 per cent preventive medicine, while remedial work should constitute only 10 per cent of their services. Unless the prevention of disease becomes the dominant practical idea of physicians and health workers, we shall lose the most magnificent opportunity ever afforded medicine to work for the improvement of humanity. In the City of New York, it is estimated that we spend $150,000,000 annually for the treatment of disease and $8,000,000 for the prevention of disease. Medical science has already made sufficient progress for a decided reversal of that proportion of 18 to 1. Humanity will be better served when the greater part of our effort is directed toward preventing sickness.

IN this connection health advertising will come into its own. The slogan, "It Pays to Advertise," has been misunderstood. Public health officers and public health organizations and the medical profession in general have felt that advertising for health implied that they were beckoning for business and that the public might misinterpret it as "paying" the medical profession only. Such an interpretation is obviously far from correct. It costs far less to get the proper treatment from a reputable doctor than it does to jump from one quack to another, from one "sure cure" to another. Health education is the foundation upon which preventive medicine is built—and effective health education will find its best outlet in advertising. Commercial advertisements urge that we chew this for health, eat that for health, wear these for health, try those for health! Yet the very persons whose business it should be to advertise health, the only ones who are qualified to tell the public what to do for health, have failed to appreciate the importance of doing so.

There is nothing in the nature of public health work which should not be made to respond to the tested methods of promotion so successfully employed in commercial fields. I dare say that health departments of the future will be advertising departments of great scale health promotion to be followed up by the private physicians. The day will come when, as health administrators, we will employ copywriters, artists and popular journalists; when we shall produce advertising copy, pictures, talkies—not in a stilted form, but in the attractive and telling form used to promote a commercial product, the only difference being that we shall be scrupulous about the accuracy of our facts. But accuracy can be attractive. There is romance in the history of disease germs, and more excitement in a fight between germs for the prize of a child's health than any ringside can offer.

MORE than fifteen years ago, when many of the larger newspapers published columns of advertisements of venereal quacks, the Department of Health ran a paid advertisement at the head of these columns, warning readers against quacks and calling attention to the services of its special clinics for venereal disease. Recently the Brooklyn and Queens Tuberculosis and Health Association prepared and displayed in the streetcars a placard calling attention to the provision in the Sanitary Code that requires a medical certificate for all children entering school for the first time. This placard urged parents to have their children examined at once by their family physician. A few weeks ago there appeared in the magazine section of the New York Times a full-page advertisement calling attention to the importance of the periodic health examination. This advertisement was paid for by the Metropolitan Life Insurance Company, the New York Tuberculosis and Health Association, the Life Extension Institute and the Milbank Memorial Fund. It was entitled, A Message to the Public—from the five county medical societies of Greater New York, the Medical Society of the State of New York, and the New York City Department of Health.

We believe that every doctor should be a public health officer and that it is incumbent upon him to carry into the home of every one of his patients the message of disease prevention. But the public stimulus should come largely from the health department. An elaboration of the plan may involve a modification of the interpretation given the code of ethics which very properly prohibits a doctor beckoning for patients. We ought not to be afraid of such a modification so long as it carries with it greater protection to the public health. It is not difficult to devise ways in which to reconcile a form of controlled advertising by doctors, and yet have it consistent with sound ethics and public health. It is clear that the health department can do much for the doctor.

AS an instance, I might mention an experiment that is being conducted in the Bellevue-Yorkville Health Demonstration area by the New York City Department of Health. A staff of nurses has been placed at the disposal of that area's doctors and dentists, to visit patients, instruct them in disease prevention and furnish the supplemental service which the physician may be unable to give in his office. Regretfully, however, we find that the physicians and dentists are slow in utilizing this service placed at their disposal.

The time is not far off when every large city will have district health centers in strategic points, just as today we have our district police and fire headquarters. The people of a community would soon protest vehemently if their particular district was not supplied with adequate police and fire protection. There is just as much need in a district for health protection, and it is to the district health center of the future that we look for that protection. The health center will serve those who are too poor to pay the private doctor—and it will also provide the physicians of the neighborhood with a central service where x-ray facilities and every means of biological analysis will be at their disposal. The doctor is the most important factor in the whole public health movement and I cannot say too emphatically that the development of these neighborhood health centers should, and would, in no wise interfere with the relationship of the patient to his private physician.

The health department can help the doctor increase his legitimate private practice through a health program, such as I have described in connection with the diphtheria campaign. But the doctor must remember that once a health department embarks upon a program to encourage people to go to a private practitioner, he must do his part to keep that patient by his professional competence, moderate charges and effective follow-up work. If the private practitioner fails to enter actively into such a health program, he has only himself to blame if the state steps in to enforce that program.

"Arts and sciences," commented Montaigne, "are not cast in a mould, but are formed and perfected by degrees, by often handling and polishing, as bears leisurely lick their cubs into form." May not the same be said for the cooperative aims of public health and private practice?

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Photo by Hiram Myers

IT DOESN'T HURT, IT TICKLES!

This exuberant young person smiles out of a booklet in which St. Mark's Hospital presents its plans for a new service for New Yorkers of moderate means

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Industry's Answer

How a Railroad Safeguards Its Employes in Health and Sickness

By PHILIP KING BROWN, M.D.

IN the rush to the gold fields in 1849-50, men came from all over the world and San Francisco grew alarmingly in numbers with all too inadequate provision for health. Our French and German argonauts promptly banded themselves together to form the French and German general benevolent societies to provide relief for members and particularly to provide medical help in a country where doctors were too few. Both organizations still live.

Ten years later the building of railroads was started and in 1864 the first Central Pacific trains were run in the state and plans for the transcontinental line were made. The country was sparsely populated; the employes of the road were men who came west in the spirit of adventure, generally without families. Few saved for the rainy days. When sickness came, most of them found themselves in dire circumstances. There was no accident compensation, and charity of fellow-workers and of the company provided what care these men received. In consequence the company, almost at the start, organized a hospital department from which has grown the oldest industrial health insurance plan in the world and one of the most successful, through which the Southern Pacific now cares for the health as well as the sickness of between 60,000 and 70,000 men.

In 1867 an old residence in Sacramento was converted into a hospital for the care of any sick or injured employe. This building was replaced in 1869 by a $64,000 hospital with 125 beds, and for many years most of the medical work was done there. Each employe paid a fee of fifty cents a month, known as hospital dues. It is reported in the History of Sacramento County that the fifty cents dues "were sufficient together with the company's contribution to defray the current expenses of the hospital." There was no real nursing, and while the medical and surgical care was the best that could be had, the compensation to doctors was very small. An uninterrupted service has been provided to employes ever since, although the dues were raised in 1925 to seventy-five cents and in 1927 to one dollar.

TODAY—sixty-two years later—there is a central hospital in San Francisco with 300 beds, a resident staff of 120 graduate nurses, nine physicians, and six technicians; and a visiting staff of eight surgeons, five physicians, twenty consulting specialists, many of whom come daily, a roentgenologist, a pathologist, a consulting pathologist, a consulting director of research, and an epidemiologist. In the last few years the staff of the hospital has trebled, until now every field of medicine and surgery has been covered. There are also six contract hospitals between Portland, Oregon, and El Paso, Texas; fourteen emergency hospitals, and in addition 456 physicians along the line, outside of San Francisco.

The dollar a month represents the total sum within which all expense must and does come, except that all traveling expense of patients to and from the central hospital, food, nursing attendance, and ambulance are met by the company, as well as all expense connected with the care of patients injured on duty. The fact remains, however, that the advances in medicine and surgery represented by better methods of study, more expensive equipments, drugs, nursing, and service generally, make the present rate too small to do all the work as well and thoroughly as it should be done. With the further addition of 100 beds for medical cases and a sanatorium operated for tuberculous patients, dues must be raised to one dollar and a half.

Epidemics must be studied. Dentistry is an essential in modern medical practice. Drugs are vastly more refined and most of them many times higher in cost than those used several decades ago. The standard of health applied to people today makes for constantly finer diagnostic methods to reveal physical defects in the very beginning, that they may be remedied before great damage is done. In the past ten years the total number of days of care given to patients has increased just 50 per cent, drugs 40 per cent, surgical dressings 45 per cent, commissary department (food handlers) 35 per cent, nursing 140 per cent, materials used in the x-ray and chemical laboratories, 650 per cent. The increase in salaries for conducting laboratory investigations in the ten years has increased 285 per cent and, due to the appointment of specialists in every department on the staff, medical salaries 380 per cent.

IF we employ men with correctable physical defects, as very often we must, it is desirable to correct these defects in their early stages. To deal fairly with labor, someone must care for conditions uncovered by careful physical examination. It has not been the rule to treat syphilis acquired before employment and in many organizations it is not treated at all. Obviously this produces a grave situation and our present chief surgeon has ruled that since many of the correctable defects are progressive and incapacitating later on, it is wise to correct them no matter how long before employment the man may have acquired his trouble. The clearing up of focal infections, therefore, is an enormously growing part of our work.

The organization of this vast enterprise for the care of between 60,000 and 70,000 men has been a matter of years of work, and credit for its excellence is due to the remarkable genius for organization of Dr. Frank K. Ainsworth, our late chief surgeon. He was a pioneer himself in the wilds of Arizona and well understood the needs of the employes in distant fields, far from skilled help in time of sickness.

Medicine has developed with giant strides and the repair-shop of twenty and ten years ago has grown into a constructive institution where every angle of sickness may be investigated and every need for surgery can be met. More

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than that, it is the aim of the present chief surgeon and executive, Dr. Walter B. Coffey, having enlarged the staff by the addition of not less than ten specialists, to enter more and more into the field of public health and research in the line of our own problems, to embark on the education of the employes to appreciate better health and how to obtain it, and to unite and strengthen the organization by giving the opportunity to staff members along the line to come to the hospital for brief periods to get any instruction they may wish.

In furtherance of these ideas, Dr. Coffey has received by gift from one of the company's directors funds for an additional 100 beds in the hospital, more laboratories for clinical work, rooms for research work, and an out-patient clinical department for the large number of employes who live in and about San Francisco. This will necessitate a further increase in technicians and medical staff.

THE services range from the early recognition of innumerable chronic diseases, like diabetes, tuberculosis, syphilis, kidney disease, and heart conditions with the consequent chance of curing or mitigating them, to the care of far advanced chronic disease which would be an impossible burden for most of the families of our patients to carry. While the hospital benefits are supposed to extend through only a year, there are patients who have spent several years in the hospital during the later period of their lives at a cost to the institution greater than the salary they would actually have earned could they have continued at work. There is no definite social service department, yet an immense deal of work in this field is covered by the staff in advising the families of the ill as to what they have to meet and preventing the long periods of demoralization which so frequently follow the care of a helpless and hopeless invalid at home.

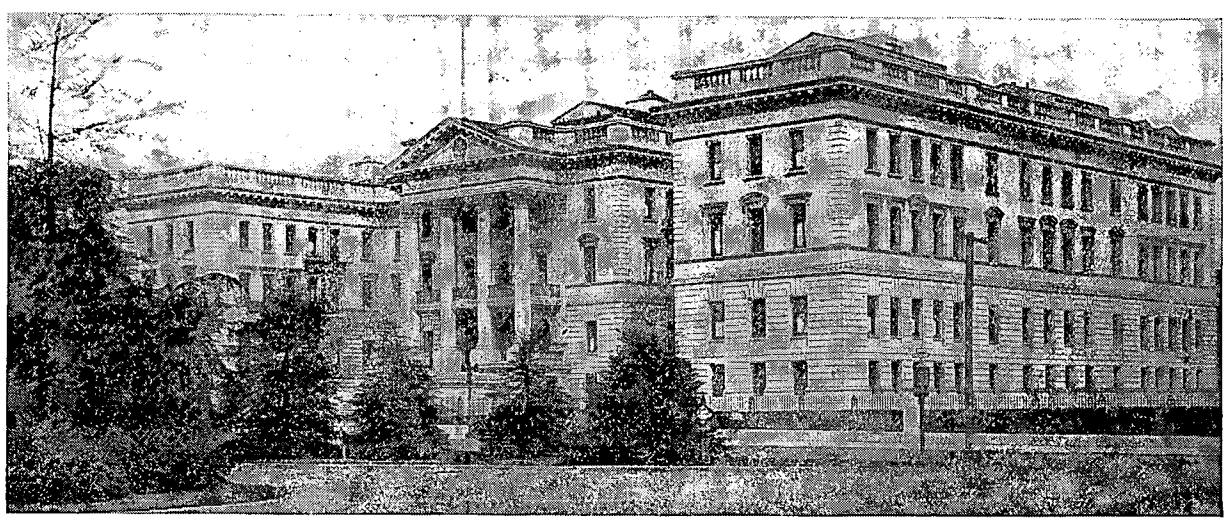
A hospital car has covered the lines of the road every year, testing the hearing and sight of men in responsible positions on the motor force, taking blood pressure, and making such other examinations as seemed indicated; and a second car is now equipped with an x-ray laboratory as well as a more extended chemical laboratory. This car will cover the outlying fields regularly where examinations will be made of cases presenting medical problems and where any of the employes may be examined if they are concerned about themselves.

In an emergency it is often necessary to employ several hundred laborers, many of them foreigners. A small percentage of these men work a few days and then break down with tuberculosis. They become charges on the company for a year and present an enormous economic problem. It would cost less than a dollar to take an x-ray plate of the chest of each such applicant for employment, and if it could be shown that they had no latent tuberculous foci, it is reasonable to suppose that they would be safe employes, because the living conditions for the laboring class in this country are relatively so good that if they have escaped the disease before reaching adult life, the chance of getting it then is comparatively small. The chief surgeon proposes to have the physicians in these cars give health talks along the line so that the employes may understand better what it is reasonable to expect from modern medical investigation, and what may be told them about the dangers that lie in the neglect of certain conditions from which they may suffer.

All handlers of food in dining-cars and the commissary service are obliged to undergo a thorough examination. They receive a complete physical examination, including nose, throat, and mouth conditions; a plate is made of the chest, a blood Wasserman test and an examination for Neisserian infection is done. If for no other than esthetic reasons, all of this is important and it has a decidedly beneficial reaction upon the men themselves. These examinations are repeated yearly and the employe must have a certificate of health.

The company publishes a monthly bulletin in which one page is devoted to answering questions about health. Only letters that are of general interest are published, and of course no names are used, but the service is so popular that forty or fifty letters a month are received.

THE out-patient department was not contemplated when the present hospital was built. Men had to be educated to come to the hospital, and at first they came reluctantly. This attitude has changed completely under the educational influence of the staff, stimulated by the vision and personal, friendly interest of the chief surgeon. The development of an out-patient department in consequence has been forced upon the hospital, and the personal contacts many of these men have established with the staff put them on exactly the same plane that would hold if the members of the staff were their private physicians. They come to the hospital because they want to, not because they have to. They understand plainly, that the company's interest, their interest, and the hospital's interest are all the same—that is, that the patients



The Southern Pacific General Hospital at San Francisco, heart of a far-flung medical system serving some 60,000 railroad men

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Typical medical ward, center of treatment and health education

should be restored to the maximum working capacity in the shortest possible time. This humanizing influence of the chief executive has given the employes a wholly new realization of what a modern hospital means.

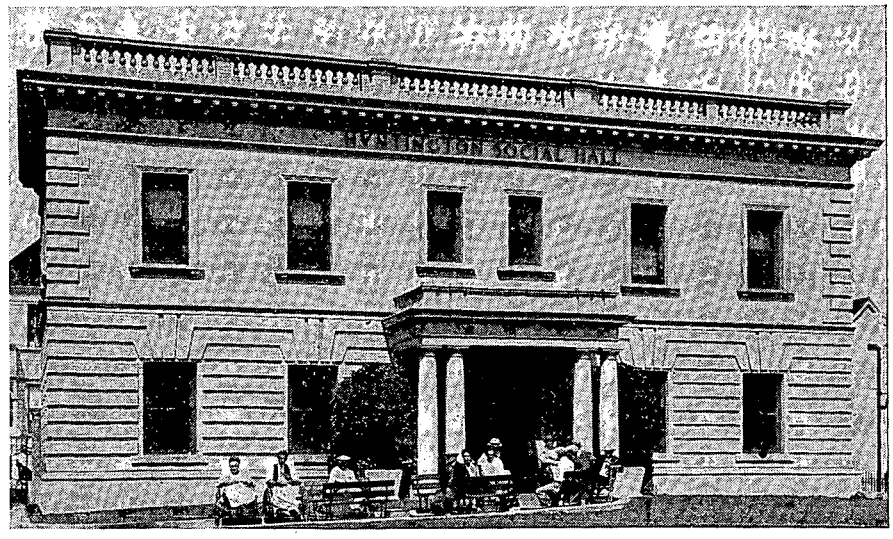
The proof of the efficiency of an educational method in handling patients dwelling not upon the magnitude of their disability but upon how they can prevent it from becoming a handicap, and how they can keep the rest of their bodies fit, shows in our record in one class of cases. One of the famous surgical clinics of the country declares that the time to operate on a peptic ulcer is when it has been cured medically ten times. Yet although our men are entitled to return for care whenever necessary, it is so seldom that they fail to learn thoroughly how to live and diet or fail to profit in every way by the lessons that are taught them, that only 15 per cent of the peptic ulcer cases return. About half of this small number come back because of some complication which requires surgical care. The rest probably represent a group who cannot be taught or do not care to take the trouble to live properly; most of them are men who have made failures of other kinds in life, and it is easy to see why they have not progressed further in the company's service.

THE hospital is after all a school of health—a goal highly developed by the present executive. He sees what insurance companies see: that sickness, not accident, is the great problem in human efficiency, for only one-tenth of the total claims paid by insurance companies are for accidents. Cases of different types are segregated as far as possible, and it is surprising how much the patients teach each other. The diabetics calculate their own diets and learn from the less fortunate that gangrene and cataract are the results of neglect. The paralytics and stiff-jointed vie with each other to overcome their handicap. The men themselves advocate the benefits of certain operative procedures and expound the relation of mouth hygiene to health. The educational scope goes beyond hospital walls to the doctors as well. When a patient is discharged from the hospital, a full report of the studies made on his case is referred back to the physician who sent him in.

Among the innovations of the present executive have been the treatment of venereal disease, the correction of handicaps existing prior to employment, and the removal of all foci of infection in every case, medical or surgical, that enters the hospital. In our experience with 25,000 Wasserman examinations, we were surprised how many times the presence of luetic infections was never even suspected by the patient. It is safe to say that it has not been due to a venereal disease in something between 10 and 20 per cent of the patients who have syphilis. The experience of *not* treating patients such as these has shown disastrous results. They are robbed right and left by quacks and not adequately treated by many private physicians, possibly because of the expense of the regular course of treatment. It seemed wise, therefore, in order to protect the employes, to do the therapy as thoroughly as it can be done.

A further change in the policy has been to abolish "releases." There was a time when employers took releases from responsibility for a man who had such defects as hernia or diseased tonsils when he was employed, and then paid no more attention to these conditions and their consequences. Our present policy is to restore people to health and, as far as possible, to prevent recurrence of their troubles. The removal of tonsils or diseased teeth is often a necessary part of such a program. No department in the hospital has grown more rapidly than these two. The presence of a crown on a dead tooth is a monument to bad technique. An enormously increased amount of dental work is being done because of the emphasis that we have put upon a clean mouth and healthy upper respiratory tract. The reason for our excellent results in the treatment of many cases depends on the fact that advantage is taken of the presence of a man in the hospital to go over him thoroughly and correct all the correctable defects, even if he came in with a broken arm and had been employed but a few weeks.

It has been the policy of the company since long before the industrial compensation days, to settle with injured men as soon as possible after accidents and employ them in any position that was possible under the rules of the unions. In this way, thousands of men who have been seriously handicapped have been kept on at work in some capacity. The union rules should be modified, for frequently they are a serious drawback to the replacing of men in industry. An



Huntington Social Hall, where convalescents spend their leisure hours

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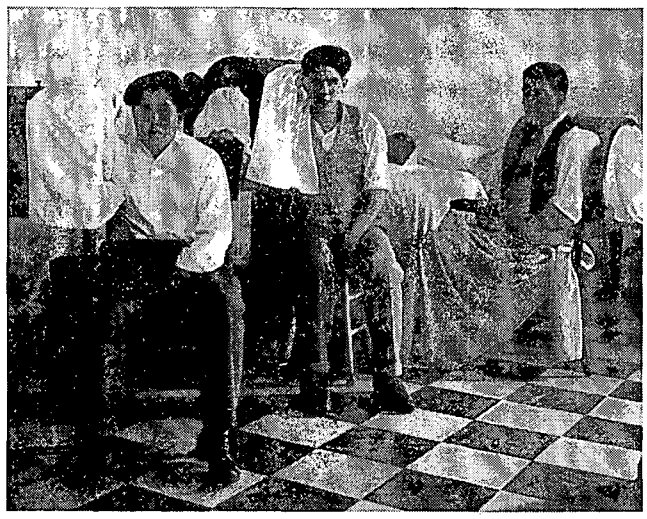
engineer who must be taken from the motor force because of heart disease, for example, is a valuable man to the company, and should be placed where he can serve the company in a capacity commensurate with his ability. A compilation as of October 1, 1926, showed a total of 407 men who had been permanently injured, settled with, and retained in service. These injuries included amputations, fractures of the skull or of limbs, impairment or loss of sight, and one case of paralysis. Yet of these 407 permanently handicapped men, 107 have had a better position since their injury than before; 175 were holding a job of the same or similar status; and only 125 were doing work of less importance.

THIS count does not include the large number of adjustments made in other than accident cases—for example, the men with impaired hearts and high blood pressure who no longer can serve on the motor force. There are almost daily efforts to transfer a man from a job whose conditions are not suitable for him to one where he can continue effectively. He may suffer from asthma or hay fever and need a change of climate, or he may have weak lungs. He may be diabetic and should live where vegetables are cheap and plentiful, not always the case in the country through which railroads run. His poor heart may make sea level better than mountains—all these things call for consideration if we would keep the men fit, and the nature of our work permits adjustments not possible in the vast majority of industries.



Baking painful joints in the physiotherapy room

Questions of public health are constantly brought home to us. We have uncovered seven epidemics of infantile paralysis by following up cases sent in to the central hospital from distant points of California. We were the first to recognize sleeping sickness on this coast and had diagnosed four or five cases before its presence was generally known. What is known as coccidioidal granuloma, a California disease, has been reported more times from our hospital than from any other single place. Tularemia, a rabbit and squirrel disease, claimed six human victims in the hospital before it was generally recognized as a serious menace to our state. These men were all brought in within a few weeks from a construction gang on a new line of road between northern California and Nevada. Our chief surgeon immediately organized an investigation of the disease and instituted measures for stopping its spread. Since that time no case has been brought into the hospital although several thousand men are at work in the infected district. This work was accomplished by cooperation between the Southern Pacific Company and its staff, the epidemiologists of the state boards of health of Nevada and California, and the Hooper Foundation for Medical Research of the University of California. Not least in our sanitary activities is the protection of thousands of water supplies along the lines.

Typhoid fever is becoming an almost unknown disease in our line hospitals. Among 10,000 entries to the hospital, it was shown that high blood pressure was 25 per cent more prevalent among office workers than among shop workers or the motor force. Obesity followed the same circumstances, except that engineers over fifty showed a tendency to gain too much weight. Angina pectoris was found especially prevalent among certain employes and the instance of peptic ulcer was so great that dietary instruction takes rank in the educational work with proper hygiene of the mouth and prompt care of all infections. The institution of every modern means of physiotherapy is an aid to convalescence and restoration of function, and a steady stream of patients pass through that department to have bath, heat, light, and electric treatments or to use the Zander apparatus on stiffened joints. Some years ago the expert on hospitals of the Rockefeller Foundation declared our hospital second to but one in America, and that was the Rockefeller Hospital in New York.

The company provides an old-age pension and carries group insurance to the amount of $500 for each worker. The employe himself may take further insurance at a low rate up to the amount of his annual salary, and most of the men do so. In the event of permanent disability or pulmonary tuberculosis monthly benefits are paid as long as the insurance lasts.

There is a strong argument for extending the hospital benefits to the families of employes, especially in instances where work requires them to live far from medical centers or even doctors, but so far this has not been done.

HEALTH service of this sort can be obtained for industrial workers in only one way—that is, by distributing the cost. Here it has been made possible by the ideals and leadership of an executive with broad vision, backed by the president of the Southern Pacific Company, Paul Shoup, and his board of directors. The factor that makes medical service more and more expensive is not the fees of physicians, which have failed to increase in the past twenty years as have the earnings of almost every other group, but the cost of laboratory investigation.

This hospital system is industry's answer to the demand of reformers for health insurance; and if legislation can do any great thing for the cause of health it will profit by the lessons of the private health insurance organizations of industry and protect them from the competition of over-advertised and poorly-run hospital benefit societies organized for profit, by standardizing service and keeping it in the hands of the regular medical profession. Industrial health service is not paternalism, but a method of distributing the excessive costs of modern investigation to make it available to all groups. Private enterprise has a duty in pointing the way of which we are not unmindful. There is room for endowment of research, for the new problems are many, and medical research may not seem a just charge on industry. It has a strong appeal to the highest class of physicians, and it should be a part of every large hospital.

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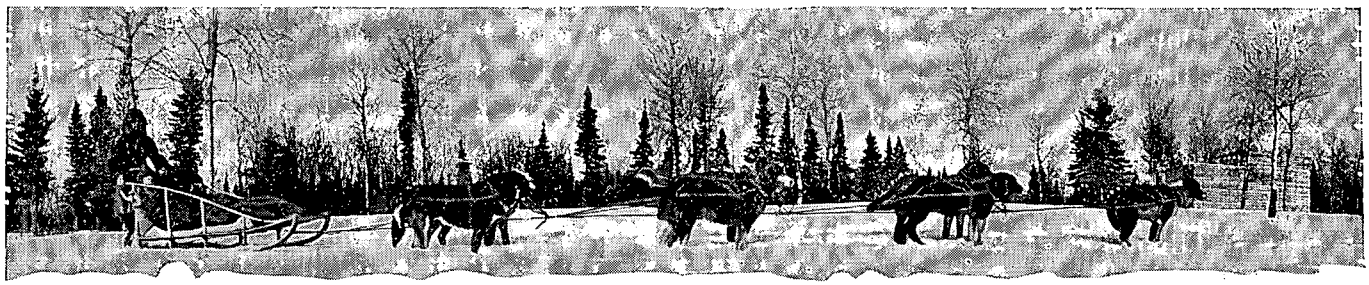

Dr. Seymour (on the sled) pursuing an influenza epidemic in the wilds of Northern Saskatchewan

Pioneers Plough a Way

By CARROLL P. STREETER

OUT on the prairies of Saskatchewan, pioneer farmers have found a plan whereby families of moderate means can pay their doctor and hospital bills without worrying about "the high cost of sickness." For there the cost isn't high. Ten dollars a year pays the farm family's doctor bill. Twelve dollars settles the hospital account. There is no extra charge when babies are born. And yet doctors make more money than the average country physicians, and hospitals have no deficits!

When word of these unusual achievements came to The Farmer's Wife, the national magazine for farm women, they seemed of such interest to us in the United States that I went to Saskatchewan to investigate. One might not expect to find an answer to the problem of sickness cost in Saskatchewan, for the homesteaders there have had their hands full with subduing the prairie, making it the "breadbasket of the world" and putting up meager sets of farm buildings, all in the last twenty-five years. In seasons of good wheat yields and markets, farmers have had comparative plenty, but when crops and prices have failed times have been hard. Yet out of these very hardships and emergencies grew the plan, in its various forms, that I had come to study. The most popular is that of paying a doctor an outright salary of $4,000 to $5,000 a year in return for free medical service. It is in use in thirteen rural municipalities, where it has had from five to eight years' trial. (A rural municipality corresponds to a county in the United States.)

The plan developed unexpectedly eight years ago when the rural municipality of Hillsburgh, in western Saskatchewan, found itself without a doctor. Crops had been poor, collections worse and the winter unusually long and severe. The doctor had gone to southern California in search of a steadier income and a warmer climate.

In this predicament, the municipal council learned that a young physician on the staff of a large hospital in British Columbia, Dr. R. K. Johnson, would consider locating in Hillsburgh, if he could be assured a living. The result of their negotiations was a contract which stipulated that the rural municipality would pay Dr. Johnson a salary of $4,500 a year in return for free treatment of all sicknesses, including maternity cases. The patients, however, would pay for hospital care, operations, specialists and medicines.

Since villages and towns are not part of the rural municipality in which they are located, Brock and Netherhill, the two villages in Hillsburgh, made separate arrangements with Dr. Johnson, together paying him $475 a year. This brought his salary up to practically $5,000 a year. As a matter of fact, however, his total income is from $7,000 to $10,000 a year, for he is allowed to practice outside the municipality provided that he takes care of his own people first.

Money to pay the doctor's salary comes from the general tax fund, resulting in a tax increase of about $10 a year for the average half sec-

What American Farm Families Paid

IN contrast to these bills of farm families in Saskatchewan come the results of a questionnaire circulated by The Farmer's Wife to which replies were obtained from 860 farm women representing every state in the Union and all types of American farming country. The total medical cost for the year ran from 0 to the $3,024.25 paid out by one Iowa family, with an average for the whole group of $104.94. Again and again a family replied they had not bought medical service when they needed it because they could not afford it, or because the doctor could not get to them or they to the doctor, in a moment of crisis. Babies, as compared to the Rosetown bargains at $8.12, ran from 0 to $1,525 for one Wisconsin youngster, with an average of $102.50 for all of them, of which about $25 went to the doctor, the rest to the hospital.

The following table shows how costs were distributed by averages for the whole group of 860 families; and also, more explicitly, by the average expenditures of the group of those who had need to call upon the special services, hospitals, nurses or the like, during the year under study. Based on the whole 860, average hospital costs, for example, were $15.12; but based upon the 185 families who actually used a hospital during the year, the average becomes $70.46.

Item	Average based on 860 families	Average based on number of families in column 3	Number of families answering question
Family doctor	$29.35	$39.14	645
Other doctors	19.23	52.35	316
Dentist	15.06	22.92	565
Hospital	15.16	70.46	185
Nurses	5.25	45.57	99
Medicines not included in the doctor's fee	7.21	10.17	610
Extra help on account of sickness	6.86	33.53	176
Other expenses due to sickness (lost wages, time, etc.)	6.82	48.09	122

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tion farm, or $3.33 per capita (of which, it happens, eighty cents is paid by absentee landlords). Medical service costs the village folk approximately the same amount per capita. When they have paid this small tax, however, they have bought the doctor's services for the year unless operations or specialists are needed.

AN important feature of the plan is the elimination of the doctor's mileage charge, usually a dollar a mile, which is often one of the chief items in the farmer's sickness cost. Dr. Johnson pays his own livery bills. This means that in Hillsburgh a farmer living fifteen miles out in the country actually pays less for the doctor's services than the man near town, for his taxes are less!

The first result of the plan is that the people out in this new country are assured the services of a good physician. They have solved the problem of "the vanishing country doctor." And the second result is that these services cost them but little. Consequently they call the doctor when they need him, rather than when they can afford him. There is a resultant saving not only in health and life itself but an immediate saving in dollars, as illustrated by an experience cited by Harry Ball, municipal clerk. When his first child was born several years ago the case was entirely normal and the doctor's fee was $35. But when his second child was born the municipal doctor had been employed and this time the cost was only $3 (the amount of his doctor tax), despite complications which caused the doctor to call seven times.

Hillsburgh people have realized, however, that there are two important prerequisites to the success of the plan: a competent, conscientious doctor, and reasonableness on the part of the people in calling him. Dr. Johnson has no competition and is assured his salary regardless of how much or how little he does, yet he goes day and night in all kinds of weather—he was lost most of one night, two years ago, in a blizzard—and drives or even walks when the roads get too tough for his automobile and snowmobile. The day I was there he made three trips to the country on maternity cases, performed a tonsillectomy and nearly lost his drugstore by fire—and the only unusual event on the program was the fire.

Dr. M. M. Seymour, for 25 years the deputy health minister of Saskatchewan Province

And as for the second prerequisite, Dr. Johnson believes that if a physician allows himself to be continually imposed on by trivial calls it is his own fault. He is no more bothered that way than in private practice. In some rural municipalities this nuisance has been prevented by allowing the doctor to charge two dollars or three dollars for the first call, with the following ones free.

If Hillsburgh's plan stopped with provision of the doctor's services it would be unusual enough, but it goes further and supplies nursing care as well. Any person who has been a resident of the community for three months is entitled to fifteen days free nursing care, if necessary, while an additional nine days is allowed for confinement cases. The rural municipality employs nurses by the day just as it needs them, sometimes having none on the payroll and sometimes ten. It pays registered nurses five dollars a day and "practical women" for the less difficult cases three dollars. Dr. Johnson decides when a patient shall have a municipal nurse and for how long, and approves all nursing bills before they are paid. During the twelve years in which the nursing plan has been in use, the cost has averaged $1,848 annually, and farm women will tell you that it's a bargain.

Dr. McDonald practices at The Gap, among patients 35 miles from a telephone

"Just the *assurance* of knowing that you will be well taken care of at childbirth is worth a lot more than the nursing service costs us," Mrs. A. B. James, a Hillsburgh farm woman, explained to me. "There are thirty women in our lodge of the United Farmers of Canada and I can guarantee that they'd kick up *some* rumpus if any 'economy' expert tried to upset our doctor and nurse tax."

Under the present arrangement every woman has skilled nursing care at childbirth as well as the services of a good doctor—and this in a new country that was only recently a frontier. Hearing of this fact, a country doctor in Manitoba wrote an article for publication advising all expectant mothers to move to Saskatchewan! The attitude of other members of the medical profession is indicated by a letter written to Mr. Ball by Dr. J. W. Crane, chairman of the Committee on Medical Survey of the Canadian Medical Association, in which he said that other rural communities might well follow Hillsburgh's "excellent example." And Dr. Johnson's opinion of the plan is indicated by the fact that he has renewed his annual contract eight times.

Added testimony is found in the fact that not a Hillsburgh mother has died from causes connected with childbirth in the last eight years. As some of these achievements have become known, inquiries asking how

Of these seven young Canadians at the Rosetown Hospital, five are the ones referred to in the article, whose mothers paid an average hospital bill of $8.12

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they came about have been received by Hillsburgh and other rural municipalities from many parts of Canada, and farm women in the United States have also shown lively interest in the plan since its description in The Farmer's Wife.

A second means whereby certain Saskatchewan communities have assured themselves a doctor is to guarantee him a minimum income. A guarantee of this sort is no doubt one of the reasons why a highly trained physician like Dr. A. McDonald, who has twice been to Europe to study obstetrics, is practicing in a place like The Gap. In this rural municipality, only thirty-five miles above the Montana line, some farmers are fifty miles from a doctor and thirty-five from a telephone. Roads are poor and often drifted high with snow. When one of these families needs a doctor in stormy weather someone must drive a team to the end of the telephone line, five to ten hours away, call the doctor (who may be twenty miles on the other side of the village), borrow a fresh team, meet him and hurry back home thirty or forty miles. Dr. McDonald told me that he has ridden as much as four thousand miles behind horses in one winter.

When I called at his office he was walking about to keep awake.

"Just missed most of two nights' sleep," he explained, "but it isn't that bad all the time. Sometimes you get four or five nights' sleep without a break."

Dr. McDonald charges fees, collects as much of them as possible and the rural municipality pays him enough more to make $5,000 a year. The amount is determined from the doctor's records, examined by the municipal clerk every month. Meanwhile, the municipality collects as many of the unpaid bills as possible.

Both wheat and youngsters grow like weeds in "the bread-basket of the world"

A third plan for keeping doctors is that of paying a bonus of $1,000 to $1,500 a year.

Thirty rural communities in Saskatchewan are successfully using some one of these three devices. Both the amounts of payment and the doctors' duties vary, but they are always stated in a written contract, which is renewed annually.

These interesting means of paying doctors, however, are only half the story of how Saskatchewan pioneers have reduced the cost of sickness. Just as unique is the way in which they have insured themselves against high hospital bills. The method is strikingly illustrated at Rosetown, a thriving little town of a thousand people in the heart of the wheat country.

The pioneers who settled there a quarter-century ago found themselves a hundred miles from Saskatoon and the nearest hospital, so they built one of their own. After a few years, however, the little Rosetown hospital seemed doomed to close because of a heavy deficit unless the four surrounding rural municipalities should take the institution off the town's hands. The farmers were willing to do so but the law did not permit it.

Consequently they dispatched J. W. Heartwell, municipal clerk, to Regina to ask Parliament for a new law, which would allow two or more municipalities to form a district for the support of a hospital. Single-handed, a one-man "lobby" from out in the western part of the province, he went down to the big stone Parliament building to accomplish his task. There he found an ally in the late Dr. M. M. Seymour, for twenty-five years deputy commissioner of health in Saskatchewan, who was interested in the same kind of legislation. Largely due to Dr. Seymour's influence the desired law was passed, authorizing union hospitals, to be supported by districts.

Now the farmers at Rosetown were assured their hospital, for the four rural municipalities formed a district and took it over. But they weren't assured that they could afford to use it. Consequently they went a step further than their new legislation allowed and instructed the municipalities to pay their citizens' hospital bills. They operated this phase of their plan for eight years without benefit of law, until Parliament finally legalized the procedure. During this time, however, they were unmolested and not a taxpayer complained.

Under the Rosetown plan a patient is admitted to the hospital on written order of a physician and he also leaves when the doctor instructs. His hospital bill is paid by the rural municipality from the general tax fund, which results in a tax increase of about $12 a year on the average farm. When the farmer pays the $12, however, he is protected against more hospital expense for a year. Rosetown has made a similar arrangement for its people, at a correspondingly low cost.

The experience of five rural mothers who were in the hospital with their new-born babies at the time of my visit demonstrates the saving to the patient. Their bills averaged $52, one exceeding $100, and were paid by their municipalities, but the amounts which the women paid averaged only $8.12—their annual hospital tax.

This low cost encourages women to come to the hospital for confinement. Furthermore, they are invited to come seven days before the babies are expected, to be sure of getting there in spite of storms and bad roads. What this means to farm women who may live far from doctor or hospital was dramatically shown one night last winter when four of them, from an average of eighteen miles out in the country, had their babies at the hospital between midnight and two o'clock in the morning. Had they stayed at home at least one would have had no doctor, for there are only three in Rosetown. But as it happened, none could have obtained a physician, for a blizzard was howling outside and country travel was out of the question. Even at the hospital, one of the women very nearly died, although she had the best of care. She had to stay in bed for several weeks. Suppose there had been no Rosetown plan and that this woman had decided to stay at home and save the bill?

That farmers are well satisfied with the plan was indicated when they recently voted, eight to one, to double the size of the hospital and run it (*Continued on page* 441)

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Health on Horseback in Lebanon

By STUART CARTER DODD

EIGHT years ago a young Syrian doctor, a graduate of the American University of Beirut, Syria, settled in his native village of Duma in the Lebanon. Gradually he acquired the confidence of the people and came to be familiar with the sicknesses and pains of every one of them.

One day Dr. Rasheed Ma'took suggested to the father of one family that they arrange a group fee for the doctor's attendance on his family, instead of paying for each visit. He pointed out that this family was large and when sickness came several of them were apt to be ill at once. The father found it difficult to pay the many fees at one time, but could do it well if they were scattered over the year. The doctor knew that on the average the total number of calls during a year to such a family did not vary greatly. So they arranged an annual fee in return for which the doctor was to care for all sickness in that family. The father now could set aside a certain amount from his income each month, or at the annual harvest time when cash could be in hand, to pay for the care of his family's health.

The idea was passed around of an evening on the village doorsteps or under the walnut tree in the vineyard of a Sunday afternoon. Other heads of families observed that when the doctor would go to that family the father did not have to think of each visit's cost. They saw that the doctor would stop there to give advice to keep the rest from catching some current sickness. Soon other families had made similar bargains with the doctor to care for their health on an annual salary basis.

The community was a typical Lebanon mountain village. One half of its nominal population of 5,000 had emigrated to better their fortune in foreign continents, but most of these still called this "home" and returned to marry, or die, or to visit their relatives. On any doorstep your host would hail passing villagers and introduce his guest—a cousin returned from twenty years in the Klondike, a neighbor who had made his fortune in Australia, a friend who was studying medicine in America, an ex-cowpuncher from the Argentine, an ex-boss in a steel mill in Pittsburgh, or his nephew away at school in Beirut. Education had come to the village seventy-five years ago and become a cult. Now 60 to 90 per cent of the people of Duma are literate in a country which is without free public schools and has in general a very low literacy rate. In the smaller villages where there is no school, the literacy is very much less.

The villages depend mostly on silk worm culture. A little wheat is grown on the floor of the valley, olive trees and grapevines for local use surround most of the houses, and sheep and goats are herded over the barren mountain slopes. The ancient cedars and all the forests have long since gone and only diligent terracing holds enough soil to grow anything. Most of the land is devoted to raising mulberry trees whose leaves support the silk worms. Wealth is reckoned by the yardstick, "he owns so and so many mulberry trees." At one tree to every three meters, this measures acreage. The harvest season is June when the cocoons are ready for sale and cash is in hand to pay all debts.

The most important social fact in these villages has been a man's religion or sect. Is the religion Moslem or Druse, Greek Orthodox or Maronite (Roman Catholic)? This is the most important consideration for professional practice or any sort of community cooperation. The sectarian enmity, bitter still, has risen to wholesale massacres within the memory of the elders. When the Greek Orthodox Dr. Ma'took came to practice, the Maronite priests and bishop preached to their flocks, warning them against patronizing him and urging that they stand by the two Maronite doctors.

In such cultural soil the health insurance plan had a struggle to grow. By persistent self-sacrifice, charging one-half the usual fees, by genuine interest in the welfare of the villagers, Dr. Ma'took grew in reputation. Gradually the entire population of several villages, including Moslem and Maronite families, came into the yearly payment system. Religious opposition subsided and the competition of the other two doctors was reduced to the status of a healthy alternative option for his clients.

An average group of Dr. Ma'took's patients

Now six hundred families are insured, about one-half of the population of the twelve villages in the valley. Six hundred families means around six thousand individuals, as in the patriarchal joint family system the average family is large. Two hundred families pay two Turkish gold pounds (about nine dollars) each a year, two hundred pay one gold pound, one hundred pay half a gold pound, and one hundred are included free. The amount to be paid by each family is determined neither by the size of the family nor by the frequency of sickness it has had in the past, but by the ability to pay. Each is assessed according to the number of mulberry trees, cattle or other sources of income he possesses. The vil-

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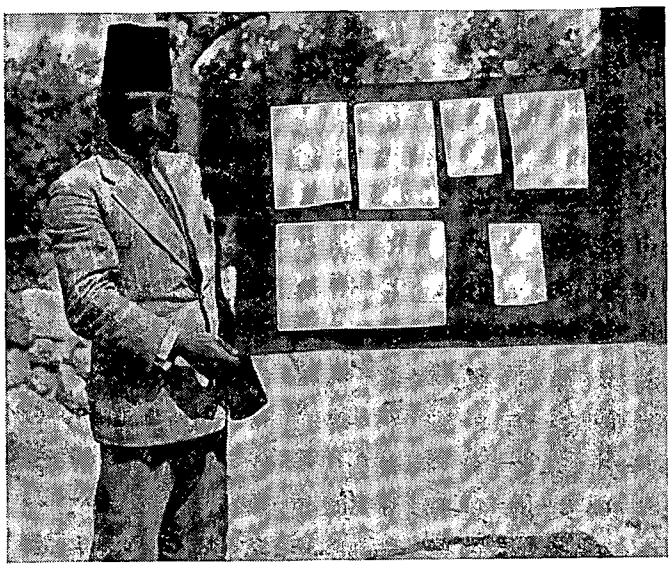

Dr. Rasheed Ma'took and the health assessment schedule decided by village vote in proportion to family income

lage meets in caucus and then the elders draw up the neatly handwritten list in Arabic script informing the doctor how the village will collect their share of his annual stipend.

Generally no difficulty is met in collecting the amount, because it is less than former doctors' fees. Public opinion strongly sanctions payment. Dr. Ma'took firmly believes that the scheme is worth continuing because of its good effect upon the general health, but, unfortunately, he had kept no statistical records of sickness to demonstrate the results in an objective form.

One big difficulty presents itself at the start and serves to deter neighboring doctors from adopting the plan more widely. When payment is no longer proportionate to the number of calls, anyone can call on the doctor for every little ache and pain and enormously increase his work. This happened to Dr. Ma'took. But instead of giving up the plan, he was driven to a defensive adaptation of a distinctly social sort. He proceeded to educate the villagers to take care of themselves. Whenever he was called for a child's digestive upset, he would call in the whole family and the neighbors and tell them what to do for such symptoms and how to feed children properly. When he visited a malaria case, the neighbors as usual would gather and he would instruct them in the use of a thermometer and quinine so that only in the most serious cases need they call for him to come riding five or six miles over the mountain trails. For contagious cases, he instructed the headman about isolation and simple techniques of disinfection so that the neighbors would insist that a child with measles be promptly isolated from the other children. This campaign of education proved so successful that now the number of calls upon him per month is less than formerly under the fee-per-visit system—and the villagers have learned hygiene.

From the social point of view, the complete shift of emphasis from curative to preventive medicine is the biggest feature to consider in evaluating the plan. Dr. Ma'took's selfish interest as well as his altruistic impulses sustain his preventive work to teach his people hygiene and sanitation. It will mean less work for him in the future if the villagers eliminate a source of mosquitoes and malaria; it will mean a more loyal clientele if he inoculates them for smallpox and they see that only clients of other doctors get the disease; it will mean not only fewer calls but greater public prestige when he insists that the school management, in order to reduce colds and measles, establishes proper hygienic precautions among the children. When the influenza swept through the country he rode from doorstep to doorstep telling the families how to guard themselves. His authority and his intimate touch with the simple villagers enable him to give health education that no amount of public print, lectures, or posters could accomplish. He advises both children and parents in the home itself, knowing its conditions and traditions. He is thus able to attack the whole situation and not the ailment or defect of one member of the family, which may often be but a symptom of the habits in the home. The family doctor, in short, has become completely "socialized."

But he is not a public health officer salaried by the government. He can be supported economically in a community which is too poor to pay taxes to support a public health department. Furthermore this plan retains a motivation which may be lacking in a government official, appointed or elected by devious ways. Here the doctor must keep the confidence of each family and give service that satisfies them or at any time they may abandon the system of annual payment and revert to a fee-by-the-visit service from a rival doctor. But without being a government official he acts as such, for his selfish interest in his practice is best promoted by interceding with the government to improve health conditions—whether the need is a mosquito campaign, free vaccine, hospital care of a destitute tuberculous or insane patient, or literature on baby welfare.

In evaluating the reasons for the success of this insurance plan, the factor of the personal qualities of Dr. Ma'took needs investigation. How far is the plan feasible elsewhere and how far is its achievement here due to his particular qualities? Some evidence on this point may be drawn from instances of the doctor's personal leadership and from the history of a plan worked out by a different doctor.

The doctor on his rounds gives instruction in matters of health and hygiene with a specific case for illustration

The health insurance plan is only one among several projects through which Dr. Ma'took is striving towards his avowed life purpose—to create cooperation among the different sects and factions in his villages in the public welfare. The project of controlling the floods of the river is famous all over the Lebanon. A rock ledge blocks the valley and prevents the swift mountain torrent from wash-

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ing the deforested hillsides out to sea as fast as they erode. Behind this ledge silt has been deposited until a strip of land two miles in length has been built up. This strip is flat in remarkable distinction from all the other rugged valleys of the Lebanon. The stream used to change its channel during the spring rains and flood the floor of the valley, killing the wheat, yellowing the mulberry leaves till the worms turned against them, and covering the fertile land with a layer of pebbles often a foot deep. Dr. Ma'took succeeded in collecting the villagers and organizing their desire to straighten and deepen the channel. The banks were bound by planting willow trees along them and by throwing up dykes of pebbles. Here and there a sluice gate of sticks would allow the water with its silt to run over the land under control while sifting out the pebbles. Each property holder in the valley was assigned a share to be paid in money or labor as he preferred.

Dr. Ma'took greets his mountaineer patients at the door of one of the typical stone dwellings

Each spring after the rains the doctor appoints a day when the villages will gather and inspect the damages, decide on repairs, and allocate shares in proportion to property ownership. The government has nothing to do with the scheme; the enforcement of the decisions upon the lazy is accomplished by the force of public opinion brought to bear in very personal and forceful ways by the neighbors and the doctor himself. Its proven advantage in enabling wheat to be grown between the mulberry trees on the valley floor and in improving all crops is the chief incentive, however, to every man to contribute his share.

Another illustration of Dr. Ma'took's capacity for leadership, which has been a factor in the success of the insurance system, was the case of the telegraph service. Negotiations had been made with the government which had agreed to furnish the wire and a wireman, if the villages would furnish the poles and labor to bring the telegraph line from the plain up two thousand feet to the valley where Duma and the other eleven villages were situated. But the villages could not raise the money. Several attempts had been made and each time the official had pocketed the contributions collected. So Dr. Ma'took decided to get action in a form which could not be frustrated by official corruption. One morning the village saw him walking down the road with a pick over his shoulder. On being questioned, he replied he was "going to dig a hole for a telegraph pole." Others followed the example of the idolized professional man turned day laborer. The idea caught fire and within two weeks, with the cooperative labor of the whole village, four hundred poles had been cut and planted and the telegraph line was brought to town.

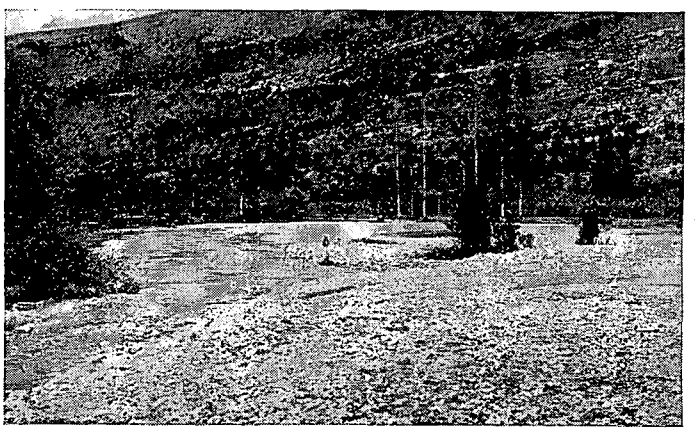
It is quite characteristic also of Dr. Ma'took that he does not believe in settling troubles and disputes among the people through the court. He aims at reconciliation and mutual understanding. His personality and prestige enabled him to assume the position of judge for the farmers and many a story is being told of how he peacefully settled a bitter quarrel. It is for this purpose that he is now studying law two months a year in the University of Damascus.

His future plans are still more adventurous. He is planning to have the villages send one of their boys to specialize in agriculture, then come back and scientifically develop the production of the valley. Building a modern hospital for the district is being discussed. Perhaps still bolder than any of these is his idea of turning the richly endowed Lebanon monasteries into centers of education!

Dr. Ma'took's own evaluation of the personal factor is worthy of being quoted: "The urgent need of my country is not for educated young men, but rather for those few of them who are willing to go back to their villages and are able to win the public confidence in leading the people to act in cooperation for the common welfare."

It should not be inferred, however, that the successful establishing of such a scheme depends upon having a person with a genius for leadership such as that of Dr. Ma'took. In the Lebanese village of Bishmazeen, another doctor had worked out independently a similar annual payment plan. When, after a few years, he transferred his practice to Iraq the villagers urged his more conservative successor to continue it. The successor says that he fears he might be called too often. But he indicates the popularity of the plan by saying that the entire village would enter immediately an annual contract with him if he should desire it.

Dr. Ma'took's kind of insurance works in a community where insurance by the government or a company is unknown and would make no headway. It comprises personal elements of confidence and individual advice and group education which no large organized insurance project can hope to include to such a degree. Under such a prospect, practice in rural regions which is now avoided by young medical school graduates, might acquire a new dignity.



A heavy deposit of pebbles covered the wheat crop and fertile soil of the flooded area in a few days' time

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HARPER'S WEEKLY.
A JOURNAL OF CIVILIZATION

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THE COUNTRY DOCTOR.—[DRAWN BY A. R. WAUD.]

FROM SADDLE-BAG—

The cure-carrier of yesterday, his coat-pockets bulging with drugs, his kit with simple instruments. Done in the romantic manner of yesterday—the delicately flowery style, the idealized figures, which sixty years ago made their appeal even to the "civilized"—this drawing by A. R. Waud suggests the time when nine-tenths of a doctor's fitness for his profession was his strength and sympathy.

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—TO LABORATORY

The scientist of today, his apparatus so complicated that to the uninitiated patient the huge forms of his office equipment recall the prehistoric room of the natural history museum. Painted in the hard, clear style of our day, the Portrait of Doctor B. by the Polish artist, Tamara de Lempicka, was one of the notable canvases in the autumn Carnegie Institute International Exhibition at Pittsburgh.

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Private Group Clinics

By C. RUFUS OREM

RECENTLY the writer had occasion to visit typical private group clinics in the Mississippi Valley and on the Pacific Coast. These visits were preliminary to a more extended study being launched under the auspices of the Committee on the Cost of Medical Care. The following comments are made from the point of view of an accountant and economist, and are not intended to deal with the medical advantages and limitations of clinical organization.

The most obvious features of group clinics are the joint utilization of such facilities as office space, laboratories, examining rooms and diagnostic and therapeutic equipment. But the more basic characteristic is that of *group medical practice,* from which results a single service to the patient and a joint income to the participating physicians. Reductions in overhead costs have been accomplished by physicians who share certain types of expenses, although they maintain and emphasize their complete independence in their practice of medicine. The group clinic, on the other hand, emphasizes the interdependence of the participating doctors. Each patient is the patient of the entire clinic, although frequently his needs may be served by only one or two members.

There is not a large number of private clinics in the United States. The invitation list of the Association of Clinic Managers includes about sixty institutions. Probably as many more would be eligible to membership. The number of physicians in each clinic ranges from five to thirty-five, although two groups are much larger. The average clinic would probably include from ten to twenty physicians. Most of the clinics are located in states west of the Mississippi river, with Minnesota and Texas leading in the total number of institutions. In each of these states the large number is directly traceable to the influence of a well-known clinic which was organized under the direction of a successful physician and administrator. Most clinics have come into existence since the World War. Some groups of doctors have used the name "clinic" to describe the offices in which they engage in practice, even though their relationships with patients and their incomes are in every respect independent.

The economic motives lying behind the formation of individual clinics are not always the same. In a large southern city, a busy surgeon realized the advantage of utilizing specialists in the diagnosis preliminary to operations. An obstetrician in a western city of 15,000 joined with a general practitioner, a gynecologist, and a nose and throat specialist, after these men had pooled their resources in the erection of a hospital. A surgeon was later admitted to the group and the number ultimately increased to nine. One clinic organization had its inception in the need for special coordinated diagnosis, although many clinic patients at present go there for treatment of minor ailments. Several physicians mentioned the advantage of being able to take regular vacations or attend scientific gatherings with the assurance that colleagues would carry on with their work. Others commented on the convenience with which specialists could be consulted, and the reduced overhead costs from group practice.

From the economic point of view, the essential feature of the clinic is the joint participation by physicians in the income of the group. The sharing of income is usually based on contract, with physicians receiving either salaries or percentages of the net income, or both. Arrangements are made for special reimbursement to persons who have invested private funds in, or loaned money to, the enterprise. A distinction is usually made between doctors who are "members" of the clinic, sharing in its profits and losses, and those who are employes, engaged on a straight salary basis. In some cases physicians are promoted from the salaried status to that of associate membership and finally to full membership.

MEMBERS do not always share equally in the net income of the clinic. The percentage of income to be received by each physician is determined in advance, and usually is not directly affected by the amount of professional work done by him during the fiscal period. In a clinic of twenty-five physicians in the Southwest, two surgeons who organized the group receive approximately one-third of its net income. A far western group of similar size divides the net income equally among seven "members." Two of these members—the chief surgeon and the pathologist—have been with the group only four years of its fifteen-year existence. It is around the distribution of net income that most difficulties in clinic administration have arisen. An inquiry in 1926 as to the causes for the dissolution of certain private clinics revealed the fact that the net income of the group was as great or greater than if the members had practiced independently. The group practice was successful financially, but no agreement could be reached for distributing this amount among the members.

Most private clinics employ a business manager, who has wide authority in regard to the administrative and financial policies and procedures. Under the general direction of the member physicians, he supervises such activities as purchasing, accounting, collections, credit investigation and maintenance of building and equipment. In some instances the business manager is a physician; usually he is a layman selected because of his general business experience or ability.

The establishment of clinic

WHAT promises and pitfalls may lie in the organization of group clinics for private patients is suggested by Professor Rorem from a preliminary study for the Committee on the Cost of Medical Care. In accord with the committee's policy, detailed data on existing clinics cannot be released till the publication of the completed report early in 1930, to be reviewed in a later issue of The Survey.

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fees is handled in much the same manner as in independent practice for similar types of services. One clinic charged a flat rate to all patients for laboratory tests, x-ray photography, and the use of apparatus. Charges for the personal services of the physician in diagnosis and treatment were based upon the estimated value of the services to the patient and upon his ability to pay. Decision as to the amount to be charged against a patient lay with the business manager, although the personal wishes of a physician were always considered in reaching a decision.

The collection of outstanding accounts from patients is a problem which has puzzled the medical profession for many years, and it is one of the most vital in the administration of a clinic. Some clinics take advantage of the facilities available for financial investigation, such as credit bureaus, banks and trade references. This procedure makes it possible to distinguish the patient who is "unable" to pay from the one who is "unwilling" to pay for his previous or contemplated medical services. Business managers, taking their lead from the practices of commercial enterprises, have a tendency to seek for volume of service through lower charges to the patients. On the other hand, they usually insist on collection of each account after it has been adjusted to the supposed ability of the patient to pay. But clinic collection methods are not necessarily hard-boiled. One large mid-western clinic has never requested or accepted a promissory note in payment of past due accounts, nor has it filed suit for payment in a court of law.

CLINICS vary in their outward appearances. One group of sixteen physicians in a town of 30,000 erected with their own investment and commercial borrowing a two-story brick structure costing approximately $150,000 when the clinic was organized in 1921. The cost of equipment and furniture brought the total investment to about $200,000. The building contains waiting rooms on two floors, and patients are assigned to the specialists whom they wish to consult in the adjoining examining rooms. There is centralized laboratory service, a pharmacy, x-ray and physio-therapy apparatus, a central accounting office, and a central lighting, heating and communicating system. The physicians attending the patients represent most of the important specialties, such as obstetrics, urology, gynecology, chest, eye, ear, nose and throat, abdominal surgery and orthopedics. A dentist also maintains an office in the building, but is not a member of the clinic group. Certain of the physicians have organized a special corporation solely for the purpose of owning the building and equipment and leasing the property to the physicians practicing medicine therein. The individual doctors maintain direct legal responsibility to the patients they treat. The clinic group does not own or operate a hospital, although the members tend to hospitalize their patients in one institution where all are members of the hospital staff. No major operations are performed in the clinic, nor minor operations which require bed care of the patient.

A very successful clinic in a large northwestern city entered into an agreement with the owner of a building during its construction. The first floor was leased to various specialty shops, including a drug store. The entire second floor was to be occupied by the clinic for a ten-year period, and was adapted at the owner's expense to the needs of group medical practice. At the end of one more year, when the lease expires, the participating physicians will move into a new building erected solely for their needs and owned by certain members of the clinic. The physicians also recently purchased a hospital, and the clinic building will be near if not actually joined to the present hospital structure.

Private clinics which choose to do so are in a position to depart from the usual sliding scale of medical fees. One clinic has established flat rates which are the maximum charge for general diagnoses, obstetrical cases, and the more common type of surgical operations. Such fees are subject to adjustment downwards where the patient's finances appear to justify such change. The members of the group are of the opinion that these flat rates yield a greater net income than the sliding scale would have provided.

THE services of a private clinic are at times directly affected by the community's need for medical care. In one western city, where all the physicians are participants in a single clinic, the group have a contract with the county to render all necessary medical care to needy or indigent patients. The amount paid to the clinic by the county is something less than 40 per cent of the value of the services at prevailing rates for medical services given by independent practitioners in similar communities.

The private group clinic illustrates the well known principle that cooperation of specialists is more economical than separate action on their part. But the care and prevention of illness is concerned with human relations. The advantages and limitations of group medical practice must be determined in terms of its ultimate contribution to the welfare of society, which includes both the medical profession and the patients. Other things being equal, it may be that group medical practice can render either more or better medical care at the same cost, or equivalent care at less cost, than the services of independent practitioners. But are the other things equal? This is the question that physicians and patients will wish to have answered.

Among the many factors which must be taken into account in a study of group medical practice are the following: the importance of a direct personal relationship between physician and patient; the net income of the average physician, as well as the unusually gifted one; the proper consideration to the patient of moderate means, who wishes medical care at a price he can afford to pay; the need for permitting the individual physician to exercise his judgment and to retain a position of respect in society; the proper emphasis on preventive medicine; the avoidance of loss of time to physician and patient through unnecessary diagnosis and treatment.

THE public generally is very much interested in private group clinics. Physicians and patients alike entertain opinions concerning their organization, policies and procedures. Some of the opinions are based on facts, others are not. The private group clinic is an experiment in the coordination of medical specialists. The study now under way will correlate facts concerning the organization, policies, and financial experience of a large group of clinics in various parts of the United States.

The foregoing impressions and facts are not intended to be final or conclusive. The ultimate acceptance of group medical practice as a general method of caring for and preventing illness will, of course, depend upon its contribution to the public welfare.

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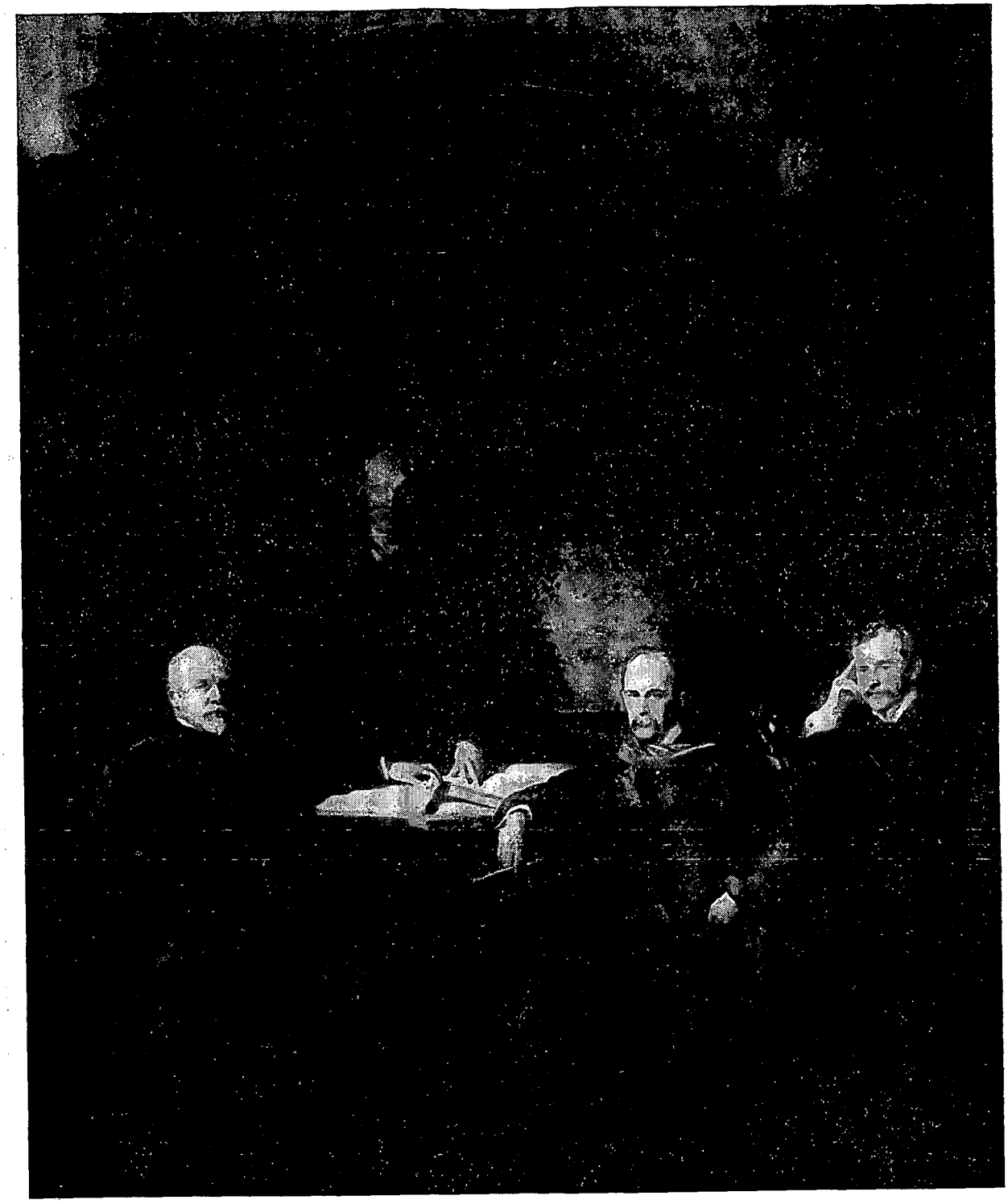

Courtesy Johns Hopkins University

THE FOUR DOCTORS

By John Singer Sargent

This famous painting now hangs in the great hall of the new William H. Welch Medical Library at Johns Hopkins. The four doctors are William H. Welch, William S. Halsted, Sir William Osler, Howard A. Kelly

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How the Foundations Fight Disease

By EDWIN R. EMBREE

THE story of the interest of American foundations in health properly begins one evening toward the close of the gay nineties when the Reverend Frederick T. Gates was on a ferry bound from his Manhattan office to his home in New Jersey. This Baptist preacher had attracted the attention of John D. Rockefeller by his habit of taking hold of impoverished congregations and putting them on their feet financially. The wealthy philanthropist, impressed, had tested the clergyman's abilities by making him fiscal agent of a number of church institutions. The result was the rapid growth of a mutual and enduring confidence. Mr. Rockefeller, richest man the world had known up to that time, found in Mr. Gates an imaginative and resourceful associate in the task of turning his huge fortune to the well-being of mankind.

On the evening in question Parson Gates noticed a fellow passenger on the ferry, absorbed in a bulky volume, altogether too large a book to justify such absorption. Gates' curiosity was stirred. He ventured a question. The book was The Principles and Practise of Medicine, by William Osler, a young professor at the young medical school of Johns Hopkins University. The name of the man with the book is unknown. He disappears from the story almost at once, but not before he has fired the Gates' imagination with a few sketchy sentences suggestive of the ideas that were at work in Osler's mind and their significance for the health and happiness of mankind.

Though unknown to fame, the young man on the ferry probably holds the world's record for arrow-in-air shooting. Mr. Gates was late in reaching his home that night, for he remained on the ferry for the return trip. Arrived back in New York, he bought the book. Thirty-six hours later he appeared, drawn and disheveled, at the Rockefeller office. Gates had read the book. He had not understood all of it, but he had caught the young man's contagion. He was convinced, and before long Mr. Rockefeller was convinced, that medicine was the thing. Here at last was a field in which millions could be spent for the betterment of mankind.

In consultation with Professor Osler and Dr. William H. Welch and others of their kind, Mr. Rockefeller and his aggressive associate formed a plan for a research institution which should be devoted exclusively to advancing the borders of medical knowledge. The Rockefeller Institute for Medical Research it was called when it opened its laboratories at the beginning of the century in rented quarters on Lexington Avenue. Today it has its own hospital and laboratories overlooking the East River, and an endowment of $40,000,000. When the institute was established, a young professor who had worked with Dr. Welch at Baltimore, Dr. Simon Flexner, was chosen as its director and he has remained in charge of this great house of research from that day to this.

The Lexington Avenue laboratory was the start of the Rockefeller interest in health. Another step on the same road was taken when Abraham Flexner, brother of the institute's director, was called to a post with the Rockefeller General Education Board. This Flexner, not himself a medical man, had made searching studies of medical education in the United States and Europe. Through the General Education Board he was able to support with millions a small number of medical schools that were willing to try out more scientific methods of teaching and research. These studies and the resulting demonstrations at Johns Hopkins and Yale and at St. Louis and Chicago were among the forces that have transformed medical education in this country.

THE first direct attack on sickness by the Rockefeller boards came on the heels of the discovery of the cause of the great anemia which was debilitating whole sections of our southern states. These were stirring times in medicine. Almost all of the basic work which de Kruif dramatized a year or so ago in his Microbe Hunters had been done or was under way. Volunteers from the American army were proving for Walter Reed in Havana that the mosquito carried the yellow fever contagion. Other American army doctors in Porto Rico, led by Dr. Bailey K. Ashford, were at work on a strange anemia found to be prevalent in that island when America took it over from Spain.

A worm with a hook-like head, a parasite in the human intestinal tract, had been identified as the cause of the disease which made strong men listless and reduced the vitality of a whole population. Through their own researches and through others dating back to the Italian, Dubini, in 1838, the army doctors traced the astonishing life history of the organism which came into the human body through the skin, usually through bare feet and, fastening itself to the intestines, sucked and poisoned the blood.

All of this was of slight interest to the people of the United States until it was discovered that the same hookworm which infested the people of Porto Rico was an unwelcome denizen of the southern states and of almost all warm countries around the globe. Dr. C. W. Stiles and others rightly thought that if the hookworm could be controlled, the South would be freed of an enervating disease which had

Dr. Hideyo Noguchi

The famous bacteriologist who died in West Africa in 1928 of yellow fever, the disease which he had so long studied for the Rockefeller Foundation

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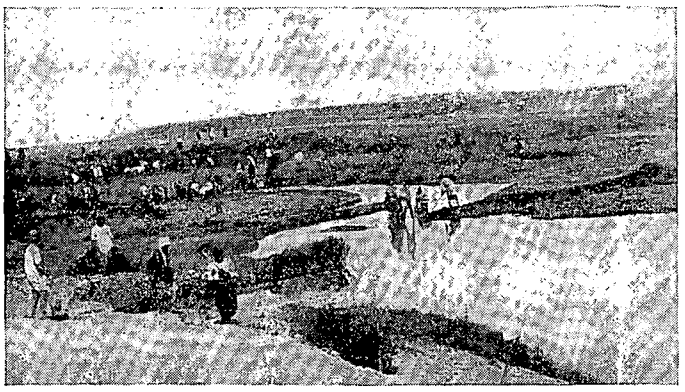
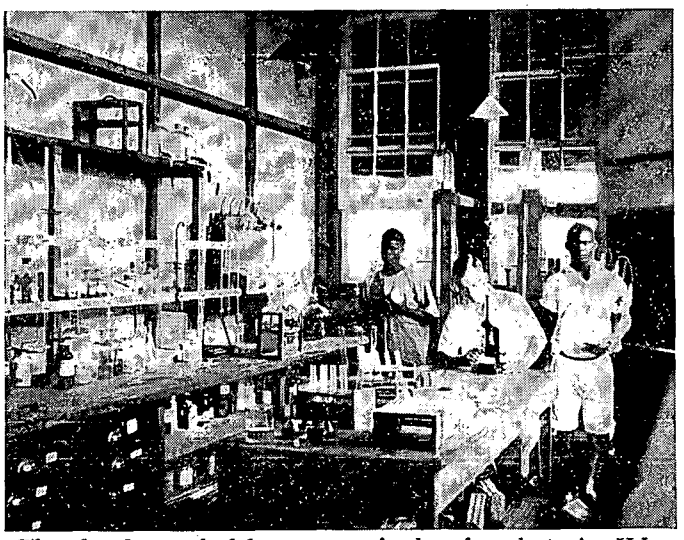


The Rockefeller Foundation, in Palestine, has a stream cleared of vegetation as an anti-malaria measure

sapped the vitality of large sections of its population for generations.

Mr. Gates saw another opportunity here for the Rockefeller fortune to use medical knowledge to promote the well-being of mankind, and his wealthy patron agreed to finance a campaign. The technique for eradicating the disease flowed directly from knowledge of the life history of the hookworm. It was easy enough to get rid of the worms in any individual's intestinal tract. A number of effective vermifuges took care of that; but, of course, there was nothing in the treatment to prevent a new batch from taking the places left vacant. Put shoes on the population, and the door through which the worm most easily entered the body would be closed. Even better, teach the population to build proper latrines and use them and the hookworm would be checkmated. That was what had to be done, and in the doing of it the later Rockefeller health activities acquired their ideas and methods. A decade after the founding of the research laboratories on Lexington Avenue, a whole new vista of Rockefeller service was opened up and the name and influence of Wickliffe Rose entered the story.



The biochemical laboratory of the foundation's West African Yellow Fever Commission at Lagos, Nigeria

In 1910 the Rockefeller Sanitary Commission was created with a million dollars to support it. Its staff and finances were independent of the research laboratories. It was engaged not in research primarily but in applying the knowledge gained through research. Hookworm was to be the first enemy and Parson Gates was looking for a man to serve as commander-in-chief. His colleague, Wallace Buttrick, then secretary of the General Education Board, spoke warmly of the work which had been done by a Tennessee professor of logic, Wickliffe Rose, as director of the Peabody Fund for promoting education and teacher training in the South. Buttrick arranged a luncheon at which Gates and Rose were to meet. Gates was captivated by the logician. As the coffee was being served, he leaned over to Buttrick to whisper, "How much shall I offer him?" The reply is not of record but before the three separated, Rose had been invited to undertake the task and had asked twenty-four hours to think it over.

Rose spent the night at the Buttrick house near Englewood, New Jersey. At breakfast the following morning his host asked what kind of a night his guest had passed. "Splendid," Rose replied. "I didn't sleep at all. But I have formulated detailed plans for the hookworm campaign and I've decided to accept."

It had been a pregnant night, indeed. The plan formulated in those hours was to be adhered to with insignificant changes for the next fifteen years, during which the Rockefeller Sanitary Commission with its million dollars grew into the International Health Board of the Rockefeller Foundation, with greatly enlarged resources and a field of activity as wide as the earth. More than that, the campaign strategy formulated by Wickliffe Rose has been thoroughly indoctrinated in the Rockefeller organization. The policies of the International Health Board in all of its subsequent campaigns derived to no small extent from Rose's program formulated that night, somewhat as follows:

> Work only with government agencies and furnish only what funds are needed to start the work. The Rockefeller organization and its financial support should be withdrawn from the field of operations as rapidly as the work can be taken over by the states and counties.
>
> Use the convincing results of work in controlling one disease as a means of persuading state and county authorities to enlarge their general health programs.

Hookworm did more than provide the Rockefeller Foundation with a philosophy and methodology. Hookworms are internationalists. In pursuing them, the Rockefeller fight on disease became international. Further, the type of

Hookworm treatment for these school children of the southern United States turned the Rockefeller Foundation into internationalists

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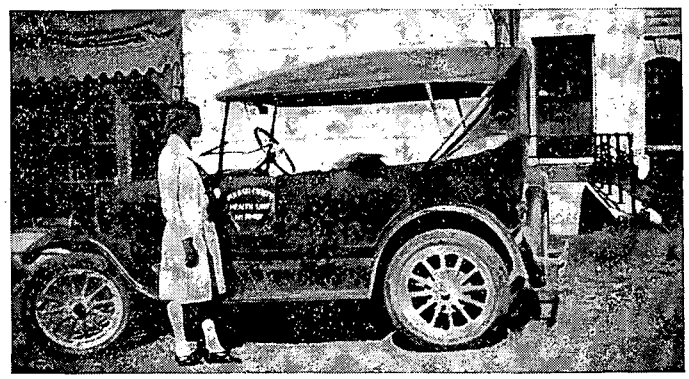
disease represented by hookworm became the kind of disease which the Rockefeller staff chose to fight. Men like to do the things they do well; and the Rockefeller staff did the hookworm kind of thing superlatively well. They were less at home in the anti-tuberculosis work undertaken in France during the war, which may account, in some part, for the gradual withdrawal from this field. There may be little in common between symptoms of hookworm disease and those of yellow fever and malaria, but they have a good deal in common in the manner in which they spread and hence in the manner in which they must be fought. In the one case, it is a question of controlling the wanderings of an intestinal worm; in the others, of making several varieties of mosquito behave. The shoes of the hookworm war were the screens of the mosquito campaigns; the latrine digging of the hookworm battles became the drainage and spraying campaigns against malaria and yellow fever.

The Rockefeller work has been done largely in rural regions and has attacked diseases in which some outside agency, worms or mosquitoes, could be controlled. If one were coining a phrase, he might say that the International Health Board is the supreme exemplar of the latrine school of public health. Had The Specialist, recently immortalized by Chic Sale, been a man of the world, aware of what others in his field were doing, humiliation at the small scale of his labors must have deprived us of his memoirs. For every work of his brain and hand, the International Health Board has hundreds and thousands to its credit. The Board has dug 5,179 in Mexico; more than a thousand in Costa Rica, where it also restored 596 works of earlier masters; 1,558 in Salvador; 61,318 in Siam, in addition to 3,350 restorations, and so on up and down and around the globe.

The board has spent, in all, more than $14,000,000 on rural sanitation, chiefly in demonstrations of the control of hookworm, malaria and yellow fever, and has worked in all of our southern states and in over two score foreign countries. The success of the hookworm demonstrations is unquestioned; the campaigns against malaria, due to the complexity of the problems, have been on the whole probably less convincing. The board has lately set itself the magnificent task of eradicating yellow fever from the face of the globe. The fight is on today in the last strongholds of the disease, West Africa and the Amazon country. The victory is still in the balance and will be so for several years to come. No one can complain that the board picked a "soft spot to light on." In addition, this board has furnished fellowships for the training of 540 public health officers of 43 countries



A Negro public health nurse of the Julius Rosenwald Fund, in Pulaski County, Arkansas

and has helped to build up schools and laboratories of hygiene.

When one includes the fundamental studies of the Rockefeller Institute for Medical Research, the promotion of scientific standards in medical education of the General Education Board and the world-wide stimulus to public health of the International Health Board, it is safe to say that no influence in world history has been greater in advancing medicine and in reducing preventable sickness than that of the boards set up by Mr. Rockefeller. With almost uncanny insight, they selected fields of world importance and backed by huge sums they occupied these fields with rare courage and statesmanship.

Other foundations have in more recent years entered the domain of health and are making their distinct and separate contributions to the study and control of sickness. The Milbank Memorial Fund, established in 1921, has supported health demonstrations of more general scope than any undertaken by the Rockefeller boards. They, too, believe that public health is properly the work of the state, the county and the municipality; and it is their purpose to discover the most effective measures which public officials may adopt. Accordingly, the Milbank fund has given financial support to three health demonstrations in New York State, one in a crowded East Side section of Manhattan Island, one in a middle-sized city — Syracuse — and the third in rural Cattaraugus County. The fund maintains, in addition, a well-staffed central research bureau which seeks, by statistical analysis and otherwise, to evaluate the effectiveness of the various health measures undertaken in these three highly diverse communities. The demonstrations were begun in 1923 and are now approaching their completion. It is still too early to state the results of these interesting experiments.

Medical examination of well babies in a small southern city, part of a health demonstration of the Commonwealth Fund

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Hot soup for school lunch in Cattaraugus County, where the Milbank Memorial Fund is making one of its three New York State health demonstrations

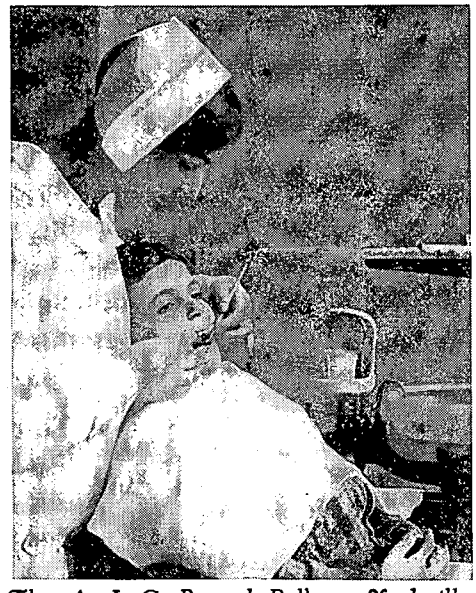
They have attracted wide attention. A gradual improvement in the technique of public health administration should result from this careful checking of the effects of old and new methods of disease prevention. Among the special projects undertaken by the Milbank Fund is a significant series of studies by engineers and others of the various methods of ventilating school rooms, with special reference to the incidence of pulmonary diseases.

The Duke Endowment, established in 1924, in addition to the building of a great university in North Carolina, is devoting millions to helping erect and maintain hospitals in the states of North and South Carolina. Ultimately the same program may be extended to other southern states. Under the vigorous direction of Dr. W. S. Rankin, this fund is giving direct aid with a profound influence upon hospital development which is likely to have effects far beyond the two states that are benefiting directly. It is helping to build a really adequate system of hospitalization on a statewide basis prepared to give service to all citizens, colored and white, rural and urban, rich and poor.

A very different attack on disease has been made by the Commonwealth Fund, endowed with some $40,000,000 by Mrs. Stephen V. Harkness. While many of its activities are outside the scope of this paper, it has made numerous and significant contributions to health. It has lent financial support to a large number of medical institutions and associations here and abroad; it is experimenting in building rural hospitals as much for the better training of the rural practitioner as for the direct service to the sick; its most distinctive activity, and from the financial viewpoint its largest, has been its interest in child health, child guidance, and mental hygiene generally. Of the foundations active in health, the Commonwealth more than any other has undertaken services in psychology and psychiatry. It maintains the Institute for Child Guidance in New York, noteworthy not only for the results achieved among the children treated—there were 627 of them in its clinics in 1927—but also for the training given at the institute to psychologists, psychiatrists and psychiatric social workers. Indeed, it was primarily to meet the need for specialists in these fields that the institute was established.

Aside from this rather specialized work of the Commonwealth Fund, the foundations have strangely neglected the great domain of the mentally sick and infirm. Yet mental diseases fill nearly as many beds in the hospitals of this country as do all other diseases put together. And ailments of the mind probably cause more personal unhappiness and social disorganization than any other group of ills. Of course the causes of mental sickness are not yet well known and methods of cure and of prevention are just beginning to be worked out. But the admitted difficulties of the subject, one would think, might be a challenge to foundations, richly endowed and in a position to pursue a great end regardless of obstacles and discouragements. Here seems to be one aspect of health not yet receiving the attention it deserves from American foundations.

The Julius Rosenwald Fund of Chicago, youngest of the foundations to enter the field, is taking an interest in two phases of health: the distribution of medical services to the man of moderate means through pay clinics, moderate-priced hospital facilities and health insurance and, as a second activity, a special push for better health among Negroes. This second activity derives directly from the interest that has been taken by the fund and by its founder, Julius Rosenwald, in the welfare of the Negro. Negroes constitute one-tenth of the population of the United States. A fifth of their number are now in northern and western states and a third of them live in cities and towns. New York, Chicago, Philadelphia, Washington and New Orleans each had more than 100,000 Negro residents as recorded in the 1920 census. The enumeration of 1930 may add St. Louis, Cleveland, Detroit, Birmingham, and Atlanta to the list. Thus the Negroes are distributed throughout the nation; they are no longer confined to the rural South. This tenth of our population is an important factor in the health of the country; for their sickness- and death-



The A. I. C. P. and Bellevue-Yorkville (Milbank Fund) dental clinic

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rates are far beyond those of the whites. In Illinois, for example, the State Department of Health found that in the four year period 1922-25 the death-rate for Negroes was 23 per thousand while that for the white population was 11.2. The improvement of Negro health is of scarcely less concern to the white population than to the Negroes themselves, for diseases do not recognize racial lines, bacteria do not obey Jim Crow laws.

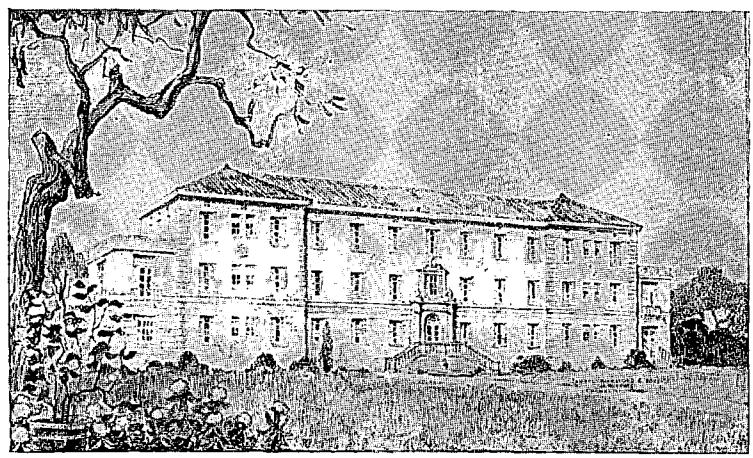
Of course, much is being done to remedy matters by state, county and municipal health departments, especially in urban centers. But much more remains to be done, particularly in the care of the Negro sick who are suffering from diseases which unlike malaria or hookworm cannot be controlled by environmental clean-ups or other mass measures. The hospital, clinic, and nursing services available to Negroes are woefully inadequate. Private medical service is relatively scanty and dental service still more so. To meet these needs the Julius Rosenwald Fund is assisting Negro medical education, as at Howard University, in Washington, D. C., and the Meharry Medical School in Nashville. It is also helping to build new hospitals for Negroes and to improve existing ones. This is done with a view not only to giving care to the sick of today but more especially to providing modern facilities for the practice and training of Negro doctors and internes and nurses. The fund is also cooperating with southern counties and northern cities in maintaining Negro public health nurses and officers of health.

The most comprehensive undertaking of the Julius Rosenwald Fund in the field of medicine is the attempt to demonstrate that it is possible to provide the best of medical care to persons of moderate means at rates which they can afford to pay and which will be adequate to compensate physicians and hospitals for their services. The philosophy underlying this project is easily understood. The interest of the plague-fighting International Health Board and its successors is only incidentally in the individual, present sufferer. The campaigns of the Rockefeller boards have been far more deeply concerned with the radical modification of pestilential environments. Yet while the great contagions are being wiped out, there still is a vast amount of individual suffering, and a great need for personal medical attention. In our cities, which form so important a part of contemporary society, the public health authorities have sanitation fairly well in hand. But they can do little for the man who needs diagnostic study, protracted medical care or a major surgical operation. The rich man can buy the services of the best surgeons, nurses and hospitals, whatever the cost; the pauper can get free treatment through the charity of physicians and institutions; but the man who is too proud to accept charity and yet too poor to pay more than absolutely required under the best organization of medical services is in a tight corner.

The Rosenwald Fund, working on the theory that medical services to the middle class patient can be made self-supporting, is giving temporary support or underwriting to certain clinics, hospitals and medical and dental groups which are making experiments to this end. Its program has in contemplation such projects as these:

1. Pay clinics for persons of moderate means in which patients pay fees approximating cost, including remuneration for the physicians. The Cornell Pay Clinic in New York City, the Clinics of the University of Chicago, and the Chicago Public Health Institute are examples of successful institutions of this class.
2. Hospital projects for bedside care of persons of moderate means, in which there is provision for dealing with the patient's total bill, i. e., both hospital charges and professional fees. The fund has helped underwrite a possible deficit during its beginning years of a special pavilion of this sort which is being built by the Massachusetts General Hospital in Boston.
3. Medical, dental and nursing services for small communities or special groups, worked out in cooperation with medical societies or other organizations.
4. Experiments in the application of the principle of voluntary insurance or instalment payments in meeting the sickness bill.

SUCH are some of the notable efforts which have been put forth by American foundations during the past quarter of a century in the battle against disease. Varying methods and differing objectives have been adopted by the several boards. The Rockefeller attack has been chiefly against the great contagions and its method has been to work exclusively with government. The Rosenwald interest is chiefly in applying modern economics to medical service and in lending a hand to the Negro as he strives for better health. The Milbank Fund is studying and testing old and new forms of health administration under the varying conditions of three types of communities. The Duke Endowment has set itself to the task of building up an adequate hospital system for all classes of the population on a state-wide basis. The Commonwealth Fund is courageous enough to attempt a drive in behalf of mental hygiene. All these foundations are taking a direct interest in the activities of the Committee on the Cost of Medical Care. The fundamental studies of this national committee should throw new light on the work which these boards have done and will continue to do in promoting the health and healing of the nations.



Design for a small general hospital in Italian Renaissance style. From a bulletin published by the Duke Endowment of North Carolina, giving information and plans suitable for small urban hospitals in rural sections

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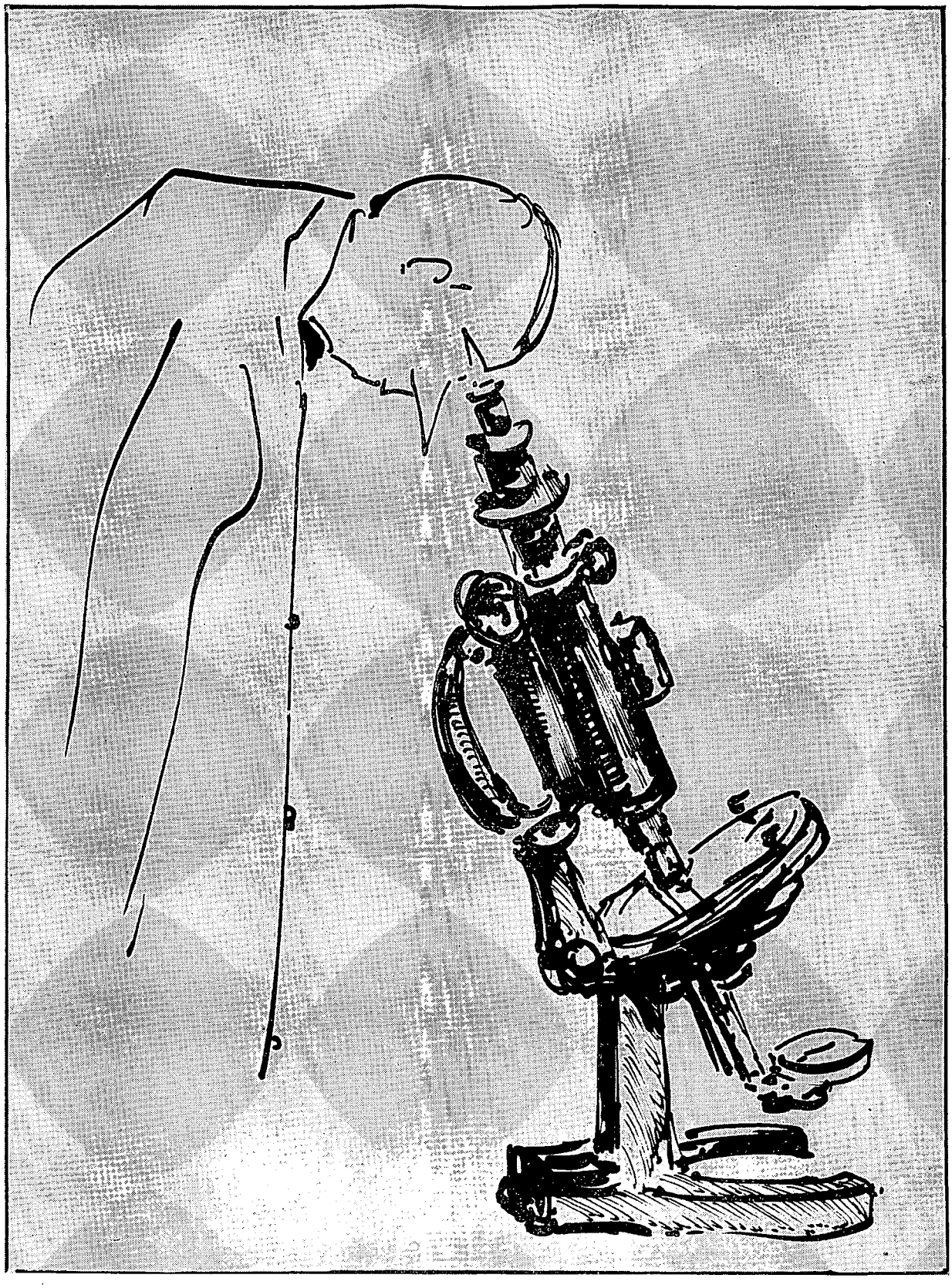

MICROBES

By Hendrik Willem Van Loon

"Strange . . . those little creatures are the smallest things alive and at the same time they are the biggest expense"

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Middle-Class Hospitals and Clinics

By MICHAEL M. DAVIS

"THE greatest of these is charity"—but as to hospitals and clinics, the whole of these was charity. Fifty years ago, Dr. W. Gill Wylie, a well-known New York physician, in a book on the history and functions of hospitals, described them as necessary for the relief of the sick poor and for medical education, believing that hospital accommodations should be limited to "those who have no homes and to those who cannot be assisted at their homes." In Dr. Wylie's time, a woman in comfortable circumstances would have felt it a social disgrace to go to a hospital for her confinement. This book was awarded the Boylston prize by Harvard University in 1876.

Hospitals were thus originally hostels for the destitute sick. The radical change in public attitude towards the hospital which has taken place since Dr. Wylie's time is really due to their increased medical efficiency. Skilled nursing has abolished the Sairey Gamps; asepsis has multiplied the opportunities and minimized the dangers of surgery. The laboratory, the x-rays and other modern facilities have increased the power of medicine to diagnose and treat disease and have enhanced the importance of the institutions which can provide and maintain these expensive facilities.

Clinics for people able to walk to the doctor were also begun as charities. Originally for the giving of medicines, they were in England and in this country medical soup-kitchens, until the hold of charity began to be loosened by the forces of medical science and public health. The modern infant welfare station, a public health clinic, is hardly a charity at all; it is a community service. The Mayo Clinic is not a charity. It is an organized medical service for a far-reaching community. Both the hospital and the clinic have moved from their historical position as serving charity straight. How far have they moved in adapting service to the public, which means the people of moderate means?

There are some seven thousand hospitals in the United States and nearly as many institutions maintain clinics. The question as to what services they are offering suggests a statistical response, presenting in carefully labelled categories how many of which are doing what and for whom. How many hospital beds are there open to families of 4.3 persons with incomes between $2,000 and $2,500 a year? What will it cost a member of one of these families for a twelve-day stay in one of these beds? What will happen to the family financially if they pay their bill promptly, and what will happen to them legally and morally if they don't?

Fortunately or unfortunately (according to the reader's liking for statistical tables), there are no such statistics for the hospitals and clinics of this country as a whole. Fortunate without question, however, is the fact that the national Committee on the Cost of Medical Care has just published a study by Professor Niles Carpenter, one of its staff, which reports information secured from about 650 of the larger general hospitals in this country.

"Formerly," says Professor Carpenter, "hospitals were built almost entirely with large wards designed for the poor." From the standpoint of medical service, there is nothing intrinsically undesirable about a ward in which twelve or twenty patients may be in sight of one another. The president of the American Hospital Association, Dr. Christopher G. Parnall, of Rochester, New York, said in a recent address that the medical service to the ward patient was of better average grade than that to the private patient, because of better selection of medical staff and better organization of the subsidiary and supervisory services. Dr. William Mayo, at the same meeting, expressed a very similar opinion. Yet, because of a desire for privacy and other conveniences, the incursion of the man of moderate means into the hospital has meant a demand for a different type of accommodation.

A group of architects reported to Professor Carpenter that whereas in 1908, 28 per cent of the beds in hospitals which they had designed in that year were in large wards (more than 10 beds), in 1928 only 7 per cent of the beds were in this group. The small ward of less than 10 beds, sometimes further divided into cubicles, the semi-private room of 2 or 3 or 4 beds, and the single rooms have in more recent hospital construction been displacing the large ward to a considerable extent. Professor Carpenter reports figures from 467 hospitals which now provide in round numbers 27,000 beds in single rooms, 15,500 in semi-private rooms and 17,000 beds in small wards. The committee report goes on to say, however, that these changes in the physical plants of hospitals have not yet gone far enough for patients of medium circumstances. "Such information as is available indicates that, in the general

Two years have passed since Michael M. Davis, then secretary of the Committee on Dispensary Development in New York City, began the publication in Survey Graphic of a series of articles on the cost of sickness, the first extended recognition by a lay magazine of a problem which since has come increasingly to public and professional attention. That same autumn of 1927 the nationally representative Committee on the Cost of Medical Care embarked on its five-year program of fact-finding and research. Here Mr. Davis, now director for medical services of the Rosenwald Fund, discusses one of the committee's first contributions, just released, a study by Professor Niles Carpenter of the ways and means developed in some general hospitals to temper the costs of infirmity to the middle-class purse with justice to institution, to the doctors, and the patient who would pay what he can.

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The Nation's Bill for Sickness

THE annual expense to the people of the United States for medical services, if itemized and totalled, would read about as follows:

150,000 physicians at $3,000 per annum.....	$450,000,000
140,000 private duty nurses at $1,500 per annum	210,000,000
150,000 practical nurses at $1,000 per annum..	150,000,000
100,000 attendants, at $1,000 per annum.....	100,000,000
50,000 dentists at $3,000 per annum.....	150,000,000
7,000 hospitals, with a total of 860,000 beds.	750,000,000
Druggists for medicines	700,000,000
25,000 healers, chiropractors, osteopaths, Christian Scientists, etc. at $2,000 per annum	50,000,000
Grand Total	$2,560,000,000

The people of the United States, it will be noted, are paying for the treatment of disease not less than $2,500,000,000 a year, or ($2,500,000,000 ÷ 120,000,000 population) $20.83 per capita, or approximately $100 per family.

The average wage-earner's family, according to studies by the U. S. Bureau of Labor Statistics, pays $60.39 a year for medical services. The average farmer's family according to studies conducted by the U. S. Department of Agriculture, pays $61.60 a year for medical services. The average family represented in the clerical personnel employed by a large insurance company pays $80 a year for medical services.

In addition to the expense for medical services imposed by disease, there is an estimated annual loss to the people of the United States of $2,000,000,000 as a result of decreased wage-earning capacity. And this is not all—there is a still further loss of permanently interrupted wage-earning capacity through postponable deaths, estimated to be $6,000,000,000 making the total annual cost of disease to the people of this country $2,500,000,000 for medical services, plus $2,000,000,000 loss in wage-earning capacity, plus $6,000,000,000 death losses—a total of $10,000,000,000 a year. The total annual income of the United States is about $90,000,000,000.—*W. S. Rankin, M. D.,* American Journal of Public Health, April, 1929.

hospitals of the country at large, there are about the same number of beds in semi-private rooms and small wards. This means that—despite notable changes in the past few years—the hospitals of this country are better equipped to serve well-to-do patients than they are to serve patients in moderate circumstances."

In other words, the hospitals of the country are now facing the problem of the middle class, but are as yet far from meeting it. Changes in the physical plant are only part of the story and it must not be forgotten that the patient of moderate means is interested first in good service, then in cost. The change from large wards to small wards, semi-private and single rooms tends to enhance comfort, but to increase cost and not to diminish it.

The patient of moderate means is also interested in having the physician or surgeon of his own choice. The ward patient traditionally could not choose his physician, but had to take whatever member of the regular hospital staff might be assigned him. This tradition is now displaced in many hospitals, wherein ward patients who pay at least "ward rates" can also have their private physician. This is particularly true in the so-called small wards. The former sharp contrast in status between the ward patient and the single-room patient is being blurred by the interposition of numerous intermediary states.

The man of moderate means is more interested in rates than rooms. Professor Carpenter's report shows that hospitals are trying many expedients in rate adjustment. One is simply the hotel plan in which each room or ward has its price, depending on size, location and the number of patients in it. A wide spread of rates can now be found, but the report shows that the proportion of beds available at the middle levels is generally small. Hospitals again are following somewhat feebly the lead of hotels in reducing or consolidating the numerous special charges—for medicines, laboratory tests, x-ray work, operating room and special nursing. These special fees may run up above the room charge and probably average as much as 30 per cent of it. A special nurse means five to nine dollars a day and two or three of them may be needed. With this particularly grievous burden a few hospitals are now wrestling. An inclusive charge for laboratory service has been for many years in some hospitals tried as an alternative to a vexatious series of special fees. Flat-rate services are appearing for certain kinds of work. Thus Professor Carpenter reports hospitals in which you can have a baby for a guaranteed maximum rate of $35 in a ward or for $60 in a semi-private room, including everything except the doctor's fee. Thus the expectant mother and her husband can more easily plan the birthday budget in advance. Similar inclusive charges for tonsillectomy or for diagnosis are being attempted in some institutions.

A more far-reaching policy is to attempt to adjust the middle-class man's rates according to his "ability to pay." He may be assigned or persuaded by the hospital admitting officer into the financial grade of accommodation which com-

What Families Have to Spend

TWENTIETH century salesmanship and its clever advertising in newspapers and magazines tend to make us overlook the fact that the pyramid of incomes in all countries, even in the United States, has a very broad flattish base, and a tall thin peak rising into the heights of luxury and publicity. The incomes of the forty-five million persons in this country who are occupied and earning run about as follows, as judged from the best available data, those of the National Bureau of Economic Research:

Incomes over $5,000, less than 1,000,000 persons, or 2 per cent.

Incomes $3,000 to $5,000, a little over 2,000,000 persons, or 5 per cent.

Incomes $2,000 to $3,000, about 6,000,000 persons, or 14 per cent.

Incomes $1,500 to $2,000, about 18,000,000 persons, or 35 per cent.

Incomes $1,000 to $1,500, about 13,000,000 persons, or 30 per cent.

Incomes less than $1,000, about 6,000,000 persons, or 14 per cent.

There averages more than one earner to a family. We must picture a great mass of families in the United States, self-supporting on between $1,500 and $2,500 a year. They are the mass who are often in a predicament because of the high cost of sickness. High-school teachers, university professors, young lawyers and five hundred thousand wives of white collar workers hasten to assure us that even though their incomes may be in the $3,000 to $5,000 group or above, they are in the predicament, too. This middle group belongs in our picture, although we generally tend to think that they are numerically a larger proportion of the self-supporting population than is really the case.—*Michael M. Davis,* The Patient of Moderate Means, The Modern Hospital, May, 1929.

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ports with "that station in life in which Providence has placed him." In the absence of divine insight, a social and financial investigation of family circumstances is necessary before judgment can be pronounced by St. Peter. Professor Carpenter's report shows that certain hospitals are undertaking this somewhat invidious task seriously and conscientiously, employing skilled admitting officers. Social workers and others who have given attention to the matter know that to determine the paying ability of an individual or family is a difficult job. Not only income, but size, standard of living and special obligations of the family need be considered, all in relation to the probable amount of the total sickness bill to be paid. What a family "ought," as distinguished from what they "can" or will pay, are also confusing discriminations. There is evidence, nevertheless, that the effort to adjust sickness bills to the patient's "ability to pay" may turn out to be a large-scale American experiment.

One way of helping the hospital patient of moderate means is to reduce his bill; another way is to make it easier for him to pay it. "Illness," as Professor Carpenter says, "creates an emergency. Often it is sudden and unforeseen." Modern business has learned that the high hurdle of a lump sum payment can be spread out into several small and easy hurdles along the track—by an instalment system, and that this increases both the client's financial ability to pay and also his psychological readiness to do so. Hospitals are just beginning to experiment with instalment plans. Some reported favorable results to Professor Carpenter; a few declared that the attempt has been unsatisfactory.

From Peter Arno's Parade, published by Horace Liveright

"Darling, here's the bill from the hospital. One more payment and the baby's ours."

It would have been interesting if the Committee on the Cost of Medical Care had been able to get reports not merely from the hospitals as to what they were doing, but from the hospital patients as to how they liked what was done. A sure guess is that many patients would want to discuss not merely their hospital bill, but the whole bill for their sickness, which included the physician's or surgeon's fee as well as the hospital charges. The patient is interested in his total bill. In a typical ten- or twelve-day hospital stay for an operation, the surgeon's fee is likely to exceed the hospital charge, often by a considerable amount. No statistics on the comparative amounts of the professional fees and hospital charges appear in Professor Carpenter's report. He does, however, bring out that a small number of hospitals are now grappling with this major problem of the middle-class patient, his total bill, aiming to get cooperation between the physician and the hospital management:

> In certain hospitals there are patients who, while not given medical attention gratis, are nevertheless charged for medical services at rates substantially lower than those charged to patients in high-priced "private" rooms. In many hospitals, arrangements of this sort are left to "gentlemen's agreements" of the staff, so that it is difficult to give any statistical evaluation of the information furnished on this question. Such material as has been tabulated suggests that physicians reduce their charges for small-ward patients in about one-fourth of the hospitals whose data have been analyzed and for patients in semi-private rooms in about one-fifth of the hospitals. . . . The Johns Hopkins Hospital limits all professional fees that are charged to semi-private patients. No physician attending such patients is expected to charge any patient more than $100 in all.

The Massachusetts General Hospital, in its new Baker Memorial Building for persons of moderate means, will have graded professional charges and the hospital will act as the physician's agent in collecting his bill from the patient. In the annual meeting of the American College of Surgeons last October, the unseemly spectacle was presented of distinguished surgeons berating hospitals for their high charges and the luxurious services with which they were said to cater to patients' whims; while, on the other hand, men well-known as hospital managers retorted with facts showing the moderateness of hospital charges in general and with intimations as to the height of surgical fees in particular. Cooperation and not recrimination is wanted between physicians and hospital managements. Suppose a hard-driven public should cry out, "A plague on both your houses," and force drastic action in the nature of publicly scheduled fees and salaried doctors.

BASIC, says Professor Carpenter, is the question: shall the future of hospital service in the United States be founded on self-support or subsidy? "Could the patient of moderate means pay for his hospital care, even if the entire hospital world should adopt every one of the new policies outlined in this study?"

The committee asks this question, but no one can answer it at present. There are few really reliable figures on what hospital costs are, because systems of cost accounting are often absent and are generally incomparable among institutions. Nor is there any indication that with the increasing demands for more and better medical service, hospital costs are likely to decrease substantially, nor are any of the administrative economies or adjustments likely to do more than nibble at the total cost. Nibbles will be worthwhile; they will alleviate, but they will not transform the situation for the middle-class patient.

The committee report leaves us at this point. The subject of medical care in clinics the committee will presumably

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The Extent of Illness and Physical and Mental Defect

Estimates from a compilation by Alden B. Mills for the Committee on the Cost of Medical Care

How often, on the average, are people hampered or definitely disabled by illness during a year?

STUDIES by the United States Public Health Service in general population of Hagerstown, Maryland, and among groups of office employes, industrial workers, and school children indicate that people, on the average, are disabled by illness *at least* once annually, the rate varying by sex and age: men about once a year, women from once to twice, and children more than twice during a school year of one hundred and eighty days. In one study variations in the number of illnesses correspond strikingly to age, the very young and the very old suffering far more frequently than persons in late adolescence and early maturity. Seasonal differences also are apparent, especially in the respiratory diseases, the winter months bringing much more illness than is found in summer.

On the basis of the *lowest* rate for disabling illness shown by these studies, there would be about 130,000,000 cases of disabling illness in the United States each year, and if non-disabling illnesses were added, this figure would be more than doubled.

How much time is "lost" by illness?

A NUMBER of studies in different places suggest that adult men lose on an average seven to eight days a year, women from eight to twelve. Of 570,000 people in industrial communities studied by the Metropolitan Life Insurance Company, roughly two per cent were ill, on the average, on a given day. The school children of Hagerstown lost seven days during a school year of one hundred and eighty days, while certain Missouri children lost ten days during the same period.

In general, therefore, it seems apparent that the 36,000,000 wage earners in the United States lose at least 250,000,000 work-days a year, and the 24,000,000 school children 170,000,000 school-days during a school-year. These figures take into account only one-half the total population.

What diseases cause these illnesses and this loss of time?

COLDS and bronchial conditions, and influenza and grippe, which occur in every list and frequently as the two leading groups, are obviously the most serious causes of disability both in frequency and days lost. Next in order came digestive diseases and disorders. Skin diseases, "rheumatism," and "headache" were surprisingly important in causing disability.

Diseases which kill, as distinguished from those which merely disable, appear in a different order of frequency in the United States Registration Area in 1927 with the five most important in order as follows: diseases of the heart, pneumonia and influenza, cancer, nephritis, cerebral hemorrhage and softening of the brain, tuberculosis.

Hospitals for mental and nervous diseases contain about 350,000 patients (about half the total number of persons under hospital care on any given time) and this number would be much larger if persons who are mentally ill but not hospitalized were included.

How many people suffer physical and mental defects and what kinds of defects are the most prevalent?

AMONG adults a great majority apparently suffer from some defect or other. A number of these defects are relatively unimportant but serious percentages are found of the more serious and dangerous conditions. Among 100,000 adult men in the prime of life examined by the Life Extension Institute, it was found, for example, that two per cent suffered from serious heart conditions, nearly three per cent from moderate hardening of the arteries, seven per cent from neurasthenia and "nervousness." Among school and pre-school children examined in six different surveys, from 65 to 95 per cent had one or more physical defects. Estimates place the number of persons in the United States who are mentally defective at more than 900,000, the blind at more than 100,000, those with major speech defects at 1,000,000 and school children wholly or partly deaf at 3,000,000.

IN summary Mr. Mills comments: "This study, although limited by the incompleteness of present data, has revealed an extent of illness and physical and mental defectiveness in the population which causes an incalculable amount of human suffering and economic loss. Some of these diseases and conditions rob the nation's people of their vitality and destroy their efficiency; others lead to sudden death and the premature cutting off of life. This continuance of disease, part of it preventable, indicates a field for the more widespread and efficient utilization of preventive and curative measures now known."

For further information about this study, which comprises a 60-page publication, about other studies by the Committee on the Cost of Medical Care and its five-year program, address the offices at 910 Seventeenth St., N. W., Washington, D. C.

report on later. A few clinics have been established not as charity, but to meet the needs of the persons of moderate means. Some of these are organized by physicians themselves as enterprises in the group practice of medicine. The Mayo Clinic is the most notable, but there are several hundred others which are going concerns in the United States, mostly in the Middle-west. How far these private group clinics have reduced cost to patients or how far they have given better service at similar cost are among the questions awaiting investigation. At clinics where services formerly were free or at a nominal fee, there has been a rapidly increasing tendency in late years to charge higher rates to patients. The leading clinics in Boston charge seventy-five cents a visit, with supplementary fees for medicines, x-rays, and the like. In New York City and several other large communities fees of fifty cents a visit and more are now common. Costs have mounted even more rapidly than fees from patients, owing to the higher level of medical service provided.

Thus the clinic patient is partly paying his way, although none of the fees thus far mentioned include remuneration for the doctors. Pay clinics properly so-called do include this, such as the clinic of the Cornell University Medical College in New York, several other pay clinics dealing with special disease in the same city, the pay clinics of the Boston Dispensary, the so-called industrial clinic of the Central Free Dispensary of Chicago, and the well-known Public Health Institute of Chicago, limited to venereal diseases. The hospital might be said to have its door ajar to the middle-class man; the clinic is just beginning to let him knock.

What of the future? If hospital costs cannot be greatly reduced by administrative economies, they can be by prevention. To diagnose and treat the vertical patient in the doctor's office or at the clinic costs on the average only a fraction as compared with the expense of caring for the horizontal patient in bed in the hospital or at home. And the horizontal patient, if given proper attention in the early or vertical stages, might not be incapacitated at all.

The really big ways of adapting hospitals to the middle-

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Medical Facilities in the United States

Estimates from a compilation by Allon Peebles for the Committee on the Cost of Medical Care

Practitioners and Other Individuals

Physicians. There are 143,000 physicians in the United States, more per 100,000 of population than in any other country in the world. While the number of doctors has not been increasing as rapidly as has the population, it does not follow necessarily that there is, or will be, an inadequate supply. Improved transportation, the growth of office practice and many other changes may have more than counterbalanced the decreased ratio of physicians to population.

Geographical distribution of physicians is decidedly uneven. In 1927 South Carolina and Montana had only 71 physicians per 100,000 people; California, at the other extreme, had 200. Various state surveys show clearly that the larger cities are oversupplied with doctors relative to population, whereas smaller places are *relatively* undersupplied.

Dentists. Dentists have increased rapidly since 1900; there are more than 67,000 in the United States. They are unevenly distributed—some urban centers have one dentist to every 500 people, some rural communities one to 4,000.

Nurses. There are approximately 200,000 graduate nurses at the present time, and the census of 1920 reported 152,000 practical nurses. The Committee on the Grading of Nursing Schools reports, "While many positions for nurses remain unfilled, there is no lack of applicants. The shortage is not in quantity, but in quality."

Some Other Groups. Included in the great army of 1,500,000 persons who deal with the care of the sick are 24,000 physicians' attendants, 12,000 dentists' assistants, 55,000 midwives, 550,000 hospital personnel, 100,000 pharmacists, and 32,000 practitioners, other than regular physicians, who take charge of cases of illness, including chiropractors, osteopaths, naturopaths, and Christian Scientists.

Institutions

Hospitals. Hospital beds have increased from 421,000 in 1898 to 890,000 in 1928. There are 7,000 hospitals in the United States and each day, on the average, they care for about 700,000 patients. Hospital facilities appear to be unevenly distributed; more than 40 per cent of the counties in the United States have no hospital for general community use. Of the entire bed capacity of the country approximately half is for nervous and mental diseases.

Clinics, Health Centers and Other Institutions. Clinics have grown rapidly from about 600 in 1910 to almost 6,000 in 1926, maintained by hospitals, governmental and private health organizations, industrial and commercial establishments, schools and colleges, trade unions, courts, prisons and charitable agencies. Somewhat different from the clinic is the health center, several hundreds of which have been established in recent years, especially since the war. In 1927 there were about 57,000 drug stores and almost 1,000 private clinical laboratories besides those in about 4,400 hospitals.

Public and Private Health Agencies

The medical services of the modern state appear notably in the fact that in 1927 federal, state and local governments controlled hospitals in which 70 per cent of all hospital service in the country was rendered. There are about twenty-five agencies in the federal government doing some kind of medical work. Aside from these are the services rendered by state and local health departments in the control of communicable disease, collection of vital statistics, control of water supply and sewage disposal, inspection of food, provision of diagnostic laboratories, and the dissemination of information regarding health and the prevention of disease. Among private health organizations, more than twenty of national scope, and a large number of local agencies provide educational services and in some cases treatment in the fields of tuberculosis, child health, heart disease, social hygiene, mental hygiene, cancer and blindness.

In summary Mr. Alden comments that the present review of medical facilities in the United States, which comprises a 90-page volume, raises such questions, now unanswerable, as:

Are present medical facilities in the United States adequate; if not, specifically how extensive is the inadequacy?

Just why have certain types of practitioners other than regularly licensed physicians and dentists become so extensive in this country and should any effort be made to reduce their number?

Exactly how may new and existing facilities be more evenly distributed in accordance with local needs?

Are the various functions concerned with the cure and prevention of disease effectively distributed between governmental agencies, private organizations and individual practitioners; if not, how may they be so distributed?

class man are to be found only in part within the walls of the hospital itself. To a large extent the needed reduction in the financial burden of hospital care is to be achieved by linking up the hospital with the medical services and particularly with the public health services of the community. Hospitals and clinics must be centers for health as well as repair shops. Ways out are also to be found through dealing with the middle-class man's financial problems on an organized instead of on an individual basis. It is inconceivable that the ingenuity of American business men, many of the leaders of whom are hospital trustees, will not find ways in which the principle of insurance can be applied to meet the financial burdens of hospital care, or that our noted Yankee skill may not successfully develop an instalment system.

These adjustments of hospitals and clinics to the needs of the whole community have already involved controversy, for while the technique of really efficient medical service in hospitals and clinics has been developed, the wider application of this technique waits upon the establishment of satisfactory relations with the practicing medical profession. Likewise dentistry and nursing must be considered in their spheres. Better mutual understanding and organized forms of cooperation between the professions furnishing service and the public receiving it are essential to durable progress.

So far as hospitals and clinics are concerned, the hopeful remedies ahead are: first, *prevention,* meaning by that both specific medical and sanitary measures which may wipe out disease and also organized services which will enable more diseases to be cared for in early and less costly stages; second, *administration,* reducing costs by economies in management and installing accounting systems to measure and guide the advance; third, *dealing with the patient's total bill,* through cooperation between the doctor and the institution in which he practices; and fourth, *making it easier for the patient to pay his bill,* by methods of instalment or insurance. There may, indeed, be more remedies in heaven than are dreamt of in this philosophy, but it would be well that at least these four were more widely disseminated upon earth.

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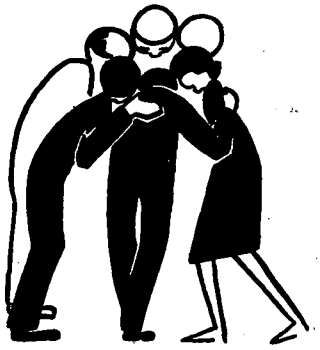
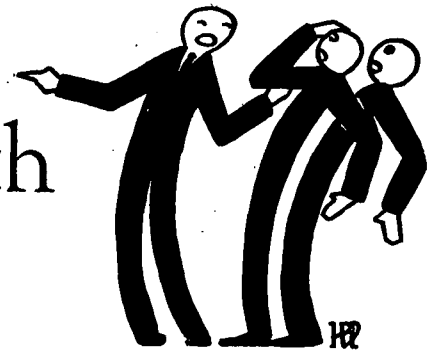


Insure for Health

By WADE WRIGHT, M.D.

Drawings by Helen B. Phelps



THERE were in this country, about fifteen years ago, groups of very earnest men and women, who frequently went into huddle plotting the promotion of compulsory state health insurance. If they huddled in public or promoted visibly or audibly, the local county medical society promptly gave utterance to piercing cries of apprehension and of anguish. Few other souls were troubled or even noticed what was going on.

The pleas of the earnest groups, branded by the doctors as militaristic and un-American, were soon drowned in the strains of martial music. The doctors joined very American draft boards or bought themselves boots and spurs and went off to camp. The pleaders became diverted by the more diverting aspects of the Great War. The critical urgency of the problems with which they had so conscientiously wrestled was no longer heralded. The "ringing challenge" of a great need echoed into a silence so silent as to be almost contemptuous. Society's foot, taking "the next great step" in social progress, remained hung in mid-air. The plow is still in the furrow, but those who guided it are not yet home from the wars. There is just a memory, that and the convulsive shudder which still agitates the spine of the body medical at thought of The Menace of State Medicine.

Meanwhile, in their ancient way, sickness, accident, unemployment, old age, and death continued to visit their ancient afflictions upon man, and man persisted in his equally ancient quest of means to mitigate his tribulations.

The continued existence of any social aggregation depends essentially upon the fair distribution of the burdens of labor and of hazard, to the end that all may benefit. Social injustices are found in unfair distribution of risks and inequitable collection of benefits. The application to the contingencies of death and illness of this quite primitive scheme for the distribution of risk has led in relatively recent years to the operation of a great variety of agencies offering life insurance and health insurance.

Until fifteen years ago practically all life and health insurance in this country, carried by licensed insurance carriers, was written on individual lives, selected as such and charged for in relation to the individual risk. About fifteen years ago the first "group" policy was issued covering a number of individuals under a single policy, each life at risk being charged for at a uniform rate. A few years later very similar methods were employed in writing group health insurance. The rapid growth of this form of protection may in part account for the subsidence of interest in the compulsory state health insurance movement of yesteryear.

GROUP accident and health insurance, not including workmen's compensation insurance, now covers not far from 2,000,000 lives. About half of this insurance is carried by one large mutual company, the balance being distributed among a number of other companies. It has about doubled in the past two years. At the present rate of growth it promises to be one of the outstanding fields of insurance within a very short time. All for very sound reasons.

Despite the fact that death is inevitable, to most men it seems a remote contingency. Sickness they know to be on every side, and sickness to the workman spells loss of working and earning power. So it is that in factories and stores, in offices and banks, on railroads and in mines working-men are voluntarily electing coverage under group health insurance policies, to guard against the cost of illness.

This voluntary coverage is a matter worth noting. With the exception of an almost negligible portion, group insurance is now written on the "contributory" basis, employes of their own choice sharing the cost of the insurance with their employers. The stern charge of "paternalism" loses much of its horror when the facts are known, though it will always be a mysterious thing to a father that "paternalism" should be a term of opprobrium and "fraternalism" redolent of sanctity. All that group insurance has done for the working-man has been to extend to him benefits which under industrial insurance

The Insurance Principle

A REMEDY for other large and unanticipated losses, which bring with them serious financial problems, has been found. In the unanticipated loss of the family of financial support by death, in the unanticipated loss of man's business by fire, in the unanticipated liabilities of estates through accidents and suits, we take advantage of the insurance principle. The insurance principle avoids unanticipated and serious financial losses by anticipating and apportioning them over long periods of time and over large groups of people. Total burdens that crush are borne easily when divided.

The insurance principle . . . appears to be the only remedy, but a most effective one for providing adequate medical care for a very large percentage of the people. Only a beginning has been made in its application. The development of sickness insurance is likely to be, in its early stages, in small and isolated groups. It holds out a strong appeal to industrial groups. Its availability to agricultural groups will probably follow a more extensive use of the principle used in the industrial centers. As its use becomes more extensive and its value more generally recognized, we may expect to see the large insurance companies embrace it as a part of their protective program. —*W. S. Rankin, M. D.*, The Economics of Public Health, American Journal of Public Health, April, 1929.

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policies would have been prohibitively expensive for him.

Many employes mutual benefit associations have, as informal, miniature insurance companies, offered somewhat similar benefits and remained solvent. They have been essentially group insurance carriers, blessed with good fortune if not with adequate cash reserves. They have served and continue to serve as very valuable agencies in softening the blows of a bludgeoning fate.

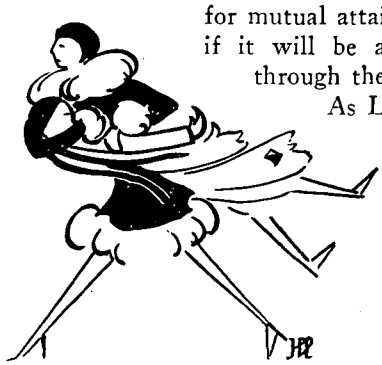
THE rationed benefits under group health insurance policies seem meager when compared with the bounteous tables d'hôte spread in prospect by the compulsory state health insurance protagonists of fifteen years ago. The benefits are cash benefits only, usually not in excess of two-thirds of the weekly earnings of the insured, and ordinarily payable after a waiting period of seven days for a maximum period of either thirteen weeks or twenty-six weeks.

Sick men and women need all of their earnings during illness—that and more. They also need funds with which to meet the expenses of medical care. They could well afford to buy insurance to meet these needs if, the needs having been properly and adequately met, the benefit payments ceased. Few of them could afford to buy insurance to meet these needs at present because of the high cost entailed by the great volume of benefits which would be paid on claims.

Sickness benefits are paid on acceptable claims for benefits, signed by the claimants and by their physicians. Most claims are, of course, honored by insurance carriers, for the ultimate objective of insurance is the payment of claims. There can be no shadow of a doubt, however, that the peril of sickness insurance, under any system of control, lies in unjust claims which can scarcely be disproved. The excessive benefits paid on these unjust claims reflect, supposedly and popularly, a nefarious purpose on the part of the claimants to dissemble, to deceive, to malinger.

EVEN if it be granted that any important proportion of claimants are so minded, still should it be noted that their dire purposes are supported and formally endorsed by an equal number of expressions of professional medical judgment, signed by physicians licensed by their respective commonwealth to practice medicine. No matter where the fingers of scorn and blame may be pointed, no matter how frequently and widely the buck may be passed, when the hue has faded and the cry is hushed, the major responsibility for this business of malingering (and what a business!) must repose firmly in the laps of an all too great number of wayward disciples of the late Aesculapius.

The most imposing obstacle to progress in the social utility of health insurance, whether written by great insurance companies, mutual benefit associations, or the Uniformed Order of Knights of the Golden Whatnot, lies in the difficulty of limiting benefit payments to those honestly due, and thus to effect savings which could be applied in accessory benefits or to lower the cost of insurance.



There is abundant evidence that a considerable number of citizens feel that some injustice has been wrought unless they can secure some very tangible return from the money they have paid in premiums for fire or burglary or automobile insurance. It is quite understandable that a man who is stricken ill may feel that his convalescence could reasonably enough be prolonged at the expense of a great insurance company too rich to care, or even at the expense of the factory mutual benefit association, or of lodge funds. An exceptionally charitable and sympathetic mind can even picture the dilemma in which that worker's physician is placed, asked to certify to the continuance of totally incapacitating illness, for that physician is a fellow-townsman of the convalescent, cares for his family and friends and gains a livelihood from ministrations to them.

When we add to that which we now know regarding the cost of medical care the facts which are soon to be available we may be able to see even more clearly than now that the real cost of competent medical service is not beyond the means of even those persons very well down in the economic scale.

The true cost of medical care is now difficult to determine, for it is obscured by data relating to "charitable" services to the indigent poor and, in many places, to a class not so poor; and by data relating to the great group of "moderate means" which is, for the lack of a better method, now commonly charged what the traffic will bear.

UNDOUBTEDLY when doctors, medical societies, hospitals, a portion of insurable individuals and the insuring bodies are ready to work together, and that time should not be far distant, it will be possible to offer insurance coverage which will pay to sick working-men totally disabled a fair approximation of their customary earnings; to those partly incapacitated, somewhat diminished benefits; and which will meet as well a large portion of the cost of required medical and hospital services. Such a plan would offer to the insured the long sought security from economic disaster in the event of sickness; to physicians it would offer assurance of certain and adequate recompense for their technical services; to hospitals it would bring relief from the financial uncertainties which have led so many reluctantly to assume the ludicrous role of the Good Samaritan packing a black-jack.

Most men and women need some better way than they now have by which to meet the great or small tragedies of illness in the home and the financial stringency it so often creates. Physicians would gladly exchange the present haphazard methods of charging for services for more secure earnings, if without threat to their professional dignity or personal freedom. Hospitals know well advantages of substituting sound business procedure for the more informal basis of operation which has long prevailed in such temples of mercy. It is scarcely conceivable that these several related needs could well be served without the application of the insurance principle.

It may be done through an extension of the group coverages now offered by great insurance carriers. It may be done by hospitals or by groups of physicians working together, or by communities of prospective patients associated together for mutual attainment of medical care. It is to be doubted if it will be accomplished, certainly in the near future, through the operation of any compulsory plan.

As Lincoln Steffens said in The Least of These, "Things grow!" Perhaps the problem of health insurance is working toward a crisis. Perhaps the "ringing challenge" or a great need is at last to be answered. It may even be that the "next great step" in social progress is soon to be taken and that Society, clutching to her bosom a somewhat bedizened figure of Hygeia, is about to get somewhere.

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The High Cost of Nursing

By JANET M. GEISTER, R.N.

THERE are many people sick in their homes today who need nursing care. Some of them are getting it from visiting nurses, others employ full-time private duty nurses, while some have practical nurses. We believe, however, that a large percentage of these sick people are doing without the care that would contribute to their comfort, security and early recovery. We believe, too, that many patients dismiss their nurses sooner than they should because of cost, and try to manage without this care through the difficult days of convalescence.

This group of people sick at home includes both the "horizontal" and the "vertical" patient—the man sick in bed and the man walking about. Among these sick in bed we find the "flu" patient, the newly delivered maternity case, the post-operative convalescent, patients who have suffered injury, and contagious disease victims. We find here, too, that great legion of "chronics" who, as a rule, cannot be accommodated in the hospitals except for short periods—the diabetics, the cancer and heart cases, paralytics, arthritic patients, who may be wholly or partly bedridden. We have, too, the aged relative whose final months or years may be spent helpless in bed.

In the walking-about group we have the patient recently dismissed from the hospital—the mother with her first baby and the medical and surgical convalescents. Our largest group of ambulatory patients is the army under care in the doctor's office, or in the clinic. None of us knows how large is this group, but we have some conception of its size when we compare the number of patients attending clinics with those who are confined to bed in the hospital. A recent study by the Committee on Registration of Social Statistics of the University of Chicago indicates that the median number for average hospitalization in nineteen cities was 3.3 patients per thousand population. Computed on the same basis, clinic and dispensary registration in these cities ranged from 13 to 120 per thousand population. We have no accurate figures covering the number of patients registered at private physicians' offices, but we estimate from various sources that about 85 per cent of our sick population are sick at home.

There is little point in arguing the value of nursing care to these people sick in their homes. Else, why do our visiting nurse associations report the annual increase in their work? Why do hospitals and clinics send field workers out to instruct patients in carrying out the doctor's orders? Modern nursing is organized to meet all the nursing needs of all manner of patients. Nursing fits itself into the plan outlined by the doctor for the patient's speedy and well-rounded recovery. This may mean instruction to the new mother in the care of the new baby—it may mean helping the patient under insulin treatment carry out the doctor's orders—or it may mean post-operative dressings. It may mean dropping in daily to bring a little nursing care and a lot of good cheer to the depressed convalescent. For the patient for whom there is no recovery in sight it means the physical and mental comfort that goes with a change of linen, a clean back and a warm bath.

There are a number of reasons why many sick people are not now under nursing care. The chief reason, we believe, is the matter of cost. Many of them cannot afford the services of a private duty nurse, especially in prolonged illnesses. Many of them realize they do not need full-time nursing service, but in many places no facilities have been provided for a less expensive amount of care. An increasing number is coming under the care of the hourly nurse service of many visiting nurse associations, though reports from a considerable number of these associations indicate that the demands for this service do not begin to compare with the needs for it. For the patients who are in communities which do not have this service, there is little alternative between doing without nursing care and purchasing the full time of two graduate nurses.

Is it possible to provide these people with the nursing they need at a price the patient in moderate circumstances can afford to pay? We believe that in the majority of instances it is, but only through a radical change in our use of nursing service. Nursing itself is not expensive. The average private duty nurse's income averages $1,400 a year. Our use of nursing service, however, on our present individualistic basis, is expensive. Too often it is beyond the means of our patient and he does without it, or else spends money he can ill afford.

THE tradition of providing continuous nursing service to every patient, with a nurse at the bedside twenty-four hours a day, was established more than fifty years ago. Those were the days when hospitals were scarce and places of dread, rather than places of hope. They were the days of hot stove-lid applications or waiting to see "what it turns into" before calling the doctor. Patients were more remote from their doctors because of muddy roads and no telephones. Typhoid fever, diphtheria and other infectious diseases were common. It was imperative to have a nurse on constant duty in the home.

Styles in sickness and in the care of sickness have changed. The great advances in medical science and the enormous increase in hospital beds, the speeding up and greater accuracy in diagnosis, the reduction of the physical isolation of our patients through better travel conditions: these have all served to demand radical changes in the methods of caring for the patient. The doctor has changed from saddlebags to beautifully equipped office. But the practice of continous nursing care, of prescribing the same amount of nursing care today as was prescribed fifty years ago, persists today.

The majority of our patients today can get along without continuous nursing care. This is constantly demonstrated in visiting nurse service and in ward care of patients. The average patient suffers no danger under *intermittent* or hourly nursing. Rather his well-being is promoted, for he does not worry over the high costs and household inconvenience of one or two full-time nurses in his home. A nurse coming

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in for three or four hours at a time, or dropping in two or three times a day, can furnish all the skilled nursing care that is needed for many patients. She can instruct someone in the household in caring for the other needs of her patient in the hours when she is not there, or perhaps no other care is needed.

Nursing the majority of our sick patients in their homes on a continuous bedside basis, means waste and waste means cost. The patient pays for the hours he does not need his nurse. True, in paying six dollars for a twelve-hour period, his cost is but fifty cents an hour, but multiply fifty cents over a long illness and costs mount. The nurse pays for this waste, too; she cannot charge what her actual nursing service is worth, but must make a flat charge for busy as well as for idle hours. Furthermore, it is the nurse who pays for the time she must wait for calls. Sickness in the individual is unpredictable. Under our present individualistic method of special nursing, one patient to one nurse, there must be a supply of unemployed nurses waiting to care for the unexpected illness or accident. The nurse herself pays for this availability. She cannot and does not charge enough in the eight months she is busy every year to carry her with any degree of comfort in the four months she is waiting for work. It must be understood, too, that her four months of unemployment do not occur in a solid block but are made up of jagged periods of waiting time scattered throughout the year, a situation inimical to planned use of this time and in the long run inimical to morale.

Other factors in considering the economics of nursing are quality and availability. Like anything else, nursing care that is not up to standard is expensive. Nursing comes so close to life and death that no one can afford poor nursing. Nursing care that is not available is also costly. If a man is ill in the slack season, he has a wide choice of good nurses. If he is ill during the busy months, or in an epidemic, he takes what he can get or goes without a nurse. Our present free-lance method of private duty nursing does not lend itself to a standardization of work, or a control of distribution. With 2,200 nursing schools in the United States sending out graduates each year, representing every degree of nursing education, there must necessarily be wide variation in the quality of available service. Further, as our free-lance method of work allows for wide latitude in the choice of cases that nurses will accept, we frequently find, on the one hand, an oversupply of nurses, and on the other, for a particular type of case, an actual shortage of nursing care.

I do not believe the average patient can pay more than he is paying today for his nursing care. Rather, he should pay less and have more of it available in the quantity and quality that he needs. The private duty nurse, however, cannot charge less than she is charging. She has reached the lowest level of annual income compatible with any degree of comfort and safety to the patient, for if the standard of living of the nurse gets too low the quality of nursing also suffers. Occupations of greater variety are available to women today than were available fifty years ago. Financial remuneration is better also. Therefore, if nursing is to attract and keep the service of women of good ability, it must offer professional and personal satisfaction at least on a par with those attainable in other fields of work. The nurse should have a larger and more regular income. She should have shorter hours and more opportunities for some life of her own—opportunities for study, for promotion and a reasonable asurance that her working life is not over before she is fifty.

DOCTOR AND NURSE

Daumier, great artist and wit, has his joke:

"How is the patient?"
"Alas, doctor, he died at six o'clock."
"Then he didn't take my medicine?"
"Yes, doctor."
"Then he took too much?"
"No, doctor."
"It must have been that he did not take enough."

Can these two objectives be attained? We believe they can, to the advantage of everyone concerned, but only if patient, doctor and nurse join hands in working out the solution. Why not a broad extension of the principles and methods of visiting nursing? It seems inevitable that for the great group of patients of modest means our nursing resources must be organized in such a way that the present waste is eliminated and distribution controlled. Practically, this means organizing graduate nurse staffs on salary under a bureau or association. This bureau, establishing a uniformly high standard of work, offers to the community nursing in smaller units than the present arbitrary twelve- or twenty-four-hour units. Such an organization, by virtue of its control of distribution, absorbs the slack in the nurse's day, thereby materially reducing costs. The patient pays for hours rather than days of nursing time.

This need not preclude the employment of private duty nurses for continuous service if the patient can afford it. Nor would it keep from the critically ill patient the continuous service he must have. This latter patient, as a rule, does not remain long in a critical state. He may, after a few days, proceed with safety and comfort with decreasing amounts of care provided under such an organization.

In making nursing service available through an organization rather than through an individual nurse, both patient and nurse have greater assurance of continuous service, high standards, lower costs and availability. The visiting nurse association has demonstrated how to distribute nursing service effectively and economically, always maintaining a high standard of work. It has followed, in organizing and maintaining its staff, the finest principles of personnel management. These principles and methods must be followed in

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any scheme for making available more abundant nursing service at a lower cost.

I believe that our rural and small town nursing needs especially will ultimately be met largely by some form of the hourly nursing plan. It seems to be the most logical solution, economically and socially, to the present problem of obtaining economical and standard nursing care in rural communities.

THERE are many varieties of hourly nursing in operation today. With the exception of a few nurse registry ventures, all hourly nursing offered on an organized basis is done by our visiting nurse associations or insurance companies. This service is usually differentiated from the other services of the visiting nurse associations, in that it is done on an appointment basis and a higher charge is made than for other calls. These charges are from $1.50 to $2 for the first hour or part of an hour, with decreasing amounts for subsequent hours in the same call. Usually this service is available only for the eight hours of the working day and for periods not longer than two or three hours. Some of the associations have arranged for night calls to be taken care of by the nurses doing maternity work, or by the nurses' registry. There are many ventures in hourly nursing on an individualistic basis. Some of these, established by lone nurses, represent the finest quality of nursing service. They are real endeavors to meet community nursing needs. Other individualistic efforts, established only to meet the convenience of the nurse, offer little to the patient except shorter units of nursing care. Night calls are poorly provided for. Many of the official nurse registries list nurses for hourly work and transfer calls to them, but accept no responsibility for the quality of the work nor the policies that are followed. The average charge in these instances is $2 for the first hour and lesser amounts for succeeding hours in the same call. A few of the official nurse registries are experimenting by employing one or two nurses for this work. In Buffalo and Detroit the nurses' registry and the visiting nurse association are working together on hourly nursing experiments.

Reports from many ventures in this field indicate a very slow rate of growth for some, while a few have failed altogether. Publicity efforts of various kinds have been used in an effort to arouse a greater demand, but these have been only partly successful. It is my opinion that the main reason the community takes so little advantage of this service is that the average householder does not know what it is—he does not realize what it can mean in his home. "Calling in a nurse" means to him bringing in the private duty nurse for continuous work. It is the only thing, he thinks, to do. When one isn't sick enough for this, then, of course, no nurse is called.

I BELIEVE that the broad extension of the intermittent or hourly nursing principle, designed primarily to bring adequate skilled service to the patient in modest circumstances, is essential if we are to reduce the cost of nursing and at the same time not lower its quality. This extension, however, depends on two major factors: the re-education of community, doctor and nurse in the use of nursing service; and the development of organized facilities for meeting all types of nursing needs. As in all purchasable things, it is the consumer who will ultimately determine whether or no he wants this form of nursing. But the consumer's taste is cultivated by judicious publicity and this is precisely what is needed in developing hourly nursing. We cannot be passive in this matter, we cannot merely "accept" calls. We must have a positive program for public education with simple explanation and demonstration kept constantly before the public through various means of repetition.

The development of organized facilities for hourly nursing must accompany public re-education in the use of nursing. Organization assures uniformity and continuity in service, development of policies endorsed by the medical profession, a positive program for searching out and meeting newer nursing needs in the community, statistical and accounting methods for measuring accomplishment and other similar benefits not possible under free lance service.

We have not begun to plumb the potentialities of this field. We cannot be satisfied until we are prepared to render every type of nursing service needed, trained and practical, twenty-four hours of every day. We must build up a nurse reserve for epidemics and other times of unusual stress. Further, we must learn how to utilize for the benefit of the community the services of the older nurse whose physical limitations do not permit a full day's active work for a variety of patients. Out of her rich experience she has much to offer in four or five hour periods to one or two patients.

THE question is frequently asked, "Who shall do the hourly nursing in our communities—the visiting nurse association, or the nurses' official registry?" No one knows. It seems rather absurd to say who shall undertake the task before we have any clear idea of its proportions. When we have explored the possibilities of hourly nursing far beyond our present knowledge then we shall know something of the nature of the demand, and the proper agency will be found to carry on the work. Will it eventually mean a preponderant service for "chronics" where bedside nursing is the greatest single need, or will it call largely for service in a group where health education has its greatest potentialities? Our task is to find out through experiment. In one community it may be the visiting nurse association which makes the major experiment; in another, the nurses' official registry; while in a third it may be done under a joint committee representing both groups together with representatives of the medical profession, hospital administration and lay public. The future will tell us which one of these groups is the logical one to carry on this extremely important community enterprise. In the meantime, the situation calls for experiment, cooperation and an open-minded attitude.

I do not believe we can progress very far in developing hourly nursing until funds are available to provide a real demonstration of its value. Hourly nursing should be self-supporting, but it requires a considerable volume of steady work to make it so. Volume of work depends on public demand and the creation of a public demand is a lengthy and a costly process. Organizing and maintaining a staff is an equally costly process. The average visiting nurse association and nurses' official registry do not have sufficient surplus funds to develop a broad hourly nursing program involving an extensive campaign of public information and the maintenance of a staff ready to answer all needs.

Has not the community some responsibility for promoting experiments that will tend to solve one of the cost features in its sickness problem? Can it discharge this responsibility most effectively at this stage by providing the capital necessary to finance projects in intermittent nursing until they become self-supporting?

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Facts to Face the Future

The Task of the Committee on the Cost of Medical Care

By RAY LYMAN WILBUR, M.D.

SOCIETY organizes itself slowly and with great waste of human effort and wealth. The slow processes of our changing social order operate constantly. Those who are trying to accelerate or to guide them find themselves in a labyrinth of opinion, tradition, habit, stubbornness, finance and widely varying viewpoints. In no field is this more evident than in the adjustment of the discoveries of science, in the field of medicine, to the actual care of the sick and the injured. When we face such pressing problems as the distressing illness of our relatives, friends, servants, neighbors or acquaintances, we are acutely conscious of the great disparities that exist at the present time in the distribution of proper medical care to the various elements in our population.

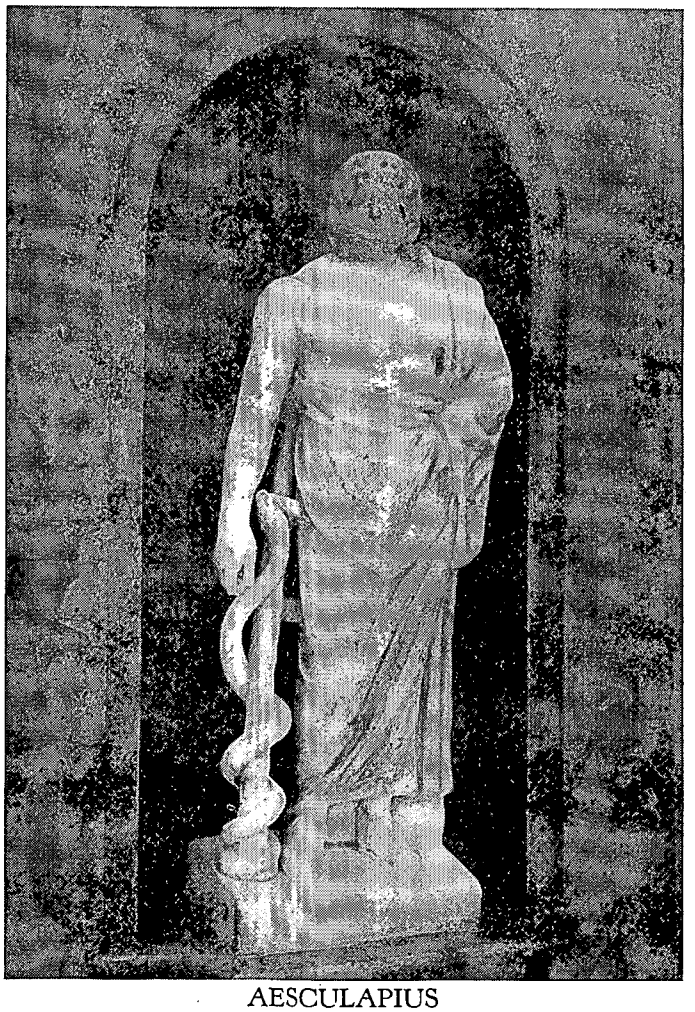
Through the combined efforts of men and women working in the laboratory, the hospital, the clinic and the home in all parts of the world, we are in possession of sufficient knowledge in both public and private health to revamp our whole civilization if it could be put into universal use.

Here in the United States we have a most interesting practical problem. Some forty-eight states with separate governments, different constitutions, different laws and different methods of thought are united in a nation working under a constitution which does not lend itself readily to a centralized plan of health administration. Here too we have a strongly individualistic and self-reliant people which has just passed through a momentous economic revolution based on discovery and invention with constantly elevating standards of living.

The health service of the people is largely cared for by physicians and surgeons trained at different periods, under different conditions, and living in states with medical practice acts of great variety. In addition, there are a large number of individuals who are without adequate training but who deal with the sick either as practitioners or by assisting them in the purchase of a great variety of drugs and remedies. Hospitals and various institutions for the domiciliary care of the sick, the insane, the aged and the pensioned are scattered widely throughout the whole country. Some of these are controlled by the national government, some by the states, some by counties, some by municipalities, some by churches, some by voluntary organizations, and others by universities, corporations and persons. An immense amount of vested wealth is gathered about the hospital bed.

We have recently gone into the automobile era, with wide-flung highways. The American people have been put on wheels, so that distance no longer has its previous significance. Only a comparatively small percentage of our people have studied biology or have anything like an understanding approach to scientific medicine. For the most part, they are woefully ignorant of the real basis upon which modern medical science is acting. A large percentage of them are ignorant of all health laws, credulous to the nth degree, and apt to view the art and science of medicine with a considerable degree of mysticism. Perhaps the most stable force in this whole problem is the organized medical profession. Yet the members of this profession are tradition-ridden and uneconomic in their thinking. They have grown up under the historical system of the charitable care of the indigent sick. They have been engrossed with their own busy lives in which they have had to concentrate all of their efforts on solving the personal, physical and mental affairs of others.

With the rapid changes going on in every phase of American life, the medical profession is constantly confronted with the fact that it is losing step, working at a disadvantage, and that unless order comes out of the present chaos in some way or



AESCULAPIUS

This statuette of the god of medicine is of great antiquity. It has recently become an acquisition of the William H. Welch Medical Library of Johns Hopkins University.

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What of the Future?

By LINSLY R. WILLIAMS

AS medical service saves money to industry, the number of physicians employed on full-time salaries will increase in this field.

As hospitals and dispensary work conserves the time of the physician and patient, the number of physicians employed in these institutions will increase. In rural counties, hospitals will be constructed and will be managed as open hospitals.

As physicians learn that group practice conserves their time and permits them to see a larger number of patients daily, they will form group practices to a larger extent.

As pay clinics are group practice and diminish cost, they will increase in number even though they may compete with private practice.

In our larger cities, the number of individualistic general practitioners will diminish in number.

An increasing number of efforts will be made to extend medical care to those who do not now get it and more adequate medical care to those whose care is now insufficient.

These efforts will be made by official and voluntary agencies.

Who will give this medical care, under what auspices, how it will be financed and how payments will be made may prove to be one of the most vexatious problems to confront us during the next decade.

As the number of medical students is limited and as medical care increases, there will be a shortage of physicians in this state within the next fifteen years.

As specialism has brought in its train a number of difficulties, the legislature will provide standards of admission to special practice.

As the value of preventive medicine is appreciated by life insurance companies, industry and the public, it will be promoted and practiced more extensively by the medical profession.

As soon as society appreciates more generally the importance of extending medical care and the possibility of diminishing its cost, the organized medical bodies will be consulted more and more when new projects are considered.—*At the annual meeting of the Medical Society of the State of New York, May* 23, 1928.

in another, abnormal solutions may be developed in some of the forty-eight states which will be of great detriment to the interests of both patients and doctors.

Such in brief is the situation facing the Committee on the Cost of Medical Care, which was organized in Washington, D. C., in May, 1927, after two years of preliminary conference with physicians, sanitarians, and economists as to the need for a new agency to study the economic factors affecting the organization of medicine. The following autumn a research staff started work actively on a five-year program of fact-finding, including preliminary surveys of existing medical needs and facilities, study of medical costs in terms of families, physicians and other agents, and analyses of specially organized facilities, such as organized medical service in industry and universities, pay and group clinics, special hospital services, or visiting nurse societies. The committee's present membership of forty-eight, charged with the direction of these studies, includes sixteen private practitioners of medicine, seven public health workers, ten representatives of hospitals, dentistry, nursing and other special interests, six economists and sociologists, and nine persons representing the general public.

Without adequate facts it seemed impossible for us to propose anything in the way of remedial measures that would be likely to live. With a committee made up of representatives of various lines of activity, and because of this with a somewhat different approach to the subject, it is hoped that we can assimilate the facts as they are brought to us by the research workers and organize finally reasonable recommendations to improve a situation now unsatisfactory to doctors, patients and public.

At first blush the physician is too intimately associated with the cost of medical care. The doctor's bill is likely to seem the outstanding element in that cost. I need only mention the dentist, the nurse, the hospital, the clinic, and the automobile, the chauffeur, the telephone, the office nurse, the bookkeeper, the landlord of the physician, to give an idea of how many elements there are in making up the total bill for medical service. Aside from his investment in his initial and his continued training, the doctor in a large city must make several thousands of dollars to pay for these services and rents before he has anything left for himself.

Some of the problems which face the committee can be suggested by considering the shortage and inaccessibility of private practitioners and of equipment in so far as many parts of the country and many people are concerned; the large number of places to which a single patient must sometimes go for the diagnosis and treatment of a single disorder; the inadequacy of the personnel and of the financial support among official and other health agencies; the extensive employment of the various cheap and inferior types of treatment; the great difficulty of securing necessary capital for medical institutions and for the support of public health and the great problem of free service and who is to pay for it. Essentially, we must remember that all sickness must be paid for from someone's savings; if the patient's, past or future savings, for during illness earning capacity largely ceases.

The fundamental cause of our present difficulty, insofar as the medical profession and the majority of the population is concerned, is that we are still mentally viewing medicine from the standpoint of the days when the doctor and his saddle-bag provided all that medical science could bring to the bedside of the typhoid case or the mother undergoing the pangs of childbirth. The problem, then, is how to get our thinking corrected and how to make available through some form of organized machinery all that medical science has to offer to all of our people desiring scientific medical care. A certain small percentage who are resistant to the dictates of common sense need not be brought in, since they will not come in.

Hundreds of recent newspaper items and magazine articles emphasize the extent and keenness of public interest in this subject. This has been spontaneous, not due to any action of the committee. The committee, recognizing that it has a great national responsibility, has endeavored to secure financial support in such a way that we can be absolutely free in any decisions which we may care to announce. A number of the great foundations have contributed generously to our work. We have had the cooperation of such agencies as the American Medical Association, the Metropolitan Life Insurance Company, the United States Public Health Service, state and local health departments, visiting nurse associations, the Social Science Research Council, the National Drug Trade Conference, the American Dental Association.

It is too early for us to know what the results are to be. All we can say is that we are on our way and that we are trying to meet the facts squarely and to work toward a typically American solution of this massive and vital problem.

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Parliaments of Persuasion

By JOHN PALMER GAVIT

TEN years of the League of Nations. During this period of world-wide celebration of the anniversary, stabilize your own estimate of the importance of this first world-experiment in neighborship by trying to imagine what would have shaped international rehabilitation during the past ten years had there been no League of Nations. The most agile imagination will falter; for the thing is stark unthinkable. Even if the League of Nations had not been deliberately and inextricably interwoven with the peace treaties, something of the sort must have been devised out of sheer necessity to avert chaos. Humanity never can be sufficiently grateful to those brave and unselfish souls who, with the aid of the logic of events, have built up the technique of common purpose and endeavor which has become the characteristic of the league and to so marked an extent and increasingly the habit of the world.

Historians will fix the official birthday of the League of Nations as January 10, 1920. On that day, at 4.15 P. M., ratifications of the Treaty of Versailles were deposited at the French foreign office in Paris by nineteen nations, including Australia, Belgium, Bolivia, Brazil, Canada, Czechoslovakia, France, Great Britain, Guatemala, India, Italy, Japan, New Zealand, Panama, Peru, Poland, Siam, Spain, and the Union of South Africa. Four other states—Argentina, Chile, Paraguay and Persia—became members by invitation to adhere to the Covenant. That is well enough for the birthday for statistical purposes; but quite as important organically, (aside from the crucial date of the signing of the treaty itself) was that day in June, 1919, more than six months earlier, when Sir Eric Drummond, the Frenchman Jean Monet, and Raymond B. Fosdick, the first three officials of the league, met in London to decide how to organize, and what to do then. There was no program, no personnel except themselves, and no money from anywhere with which to acquire a personnel. For such stenographic help as they had to have, they paid out of their own pockets. I don't know whether they ever were reimbursed; but I imagine they felt it a good investment. Nowhere in history was any precedent to guide them—they were feeling their way into a wilderness without guide-posts, maps or trails. Around them the wreckage of all stabilities and the horrid pollutions left over from the most diabolical of wars; in an atmosphere still poisonous with fear, and with ancient hates immensely aggravated.

"The Covenant spoke," says Fosdick, "of certain duties of the projected League of Nations. We wrote them down on a sheet of paper. . . ."

It would require all the space in this issue of Survey Graphic even to summarize what has developed in these ten years out of that first brief list of possible tasks and activities. One thing worthy of special notice is that from that very beginning it has been recognized that it would not be sufficient for the league to occupy itself with the mere prevention of war, the pale abstraction of "peace." Its activities must be affirmative, and manifold in the interest of human welfare. That first little list enumerated several subjects, but the prevention of war was not among them; it was seen even then that that must be a by-product; or, rather, a natural consequence, inevitable from international cooperation in concrete matters of common concern. As Fosdick remembers it:

> Registration of treaties, mandates, traffic in women and children, traffic in opium and other dangerous drugs, traffic in arms, the prevention and control of disease, cooperation with existing international bureaus—all these matters were listed in the Covenant and we conceived them as possible subdivisions or committees of the league.

IN the year before that, General Jan Smuts, in his famous pamphlet, The League of Nations, published just after the Armistice, had struck somewhat the same note:

> Peace and war are the resultants of many complex forces, and those forces will have to be gripped at an earlier stage of their growth if peace is to be effectively maintained.

These considerations have been of the very genius of the league from its beginning: that the roots of international relations and conflict lie in things and conditions of ordinary life, and that therefore conflict can be avoided only by cooperative preparedness and understanding as regards those things. For example, in the first serious conflict submitted to the league, that between Sweden and Finland over the Aaland Islands lying between them at the entrance to the Gulf of Bothnia, it was necessary to explore questions chiefly geographical, geological, ethnological. This was done by experts in those fields, and although the islands lie (to surface appearances) nearer to Sweden, they were awarded to Finland, and Sweden accepted the award. When Austria appealed to the league for help in her dire financial straits, she found that the economic experts already had collated the data necessary for a solution. The so-called "Dawes Plan" for the handling of the German reparations business was in substance the work of the league's economic section. Probably nowhere on earth is there ready at hand so complete a bulk of the technical information essential to the solution of any international dispute.

In general, there has grown up out of experience, by the mere attrition of successive and interlocking facts in the life of the world since the war, a *habit of continuous conference,* taking the place of the sporadic gatherings in an atmosphere of mutual suspicion and hand-to-mouth information which used to prevail. Almost every year since the timid beginnings, the league has had to face and compose situations any one of which in the older day might have precipitated war. Every one of them has dissolved under the process which has come to be taken as a matter of course. So much so that it is hard to realize that it has not always been so. Hard to remember that formerly the conference took place always *after* the war.

Continuously also there has gone on that other process of cooperation in economic, hygienic, humanitarian and other scientific and exploratory ways and directions which in itself would have justfied the existence of the league.

THERE was a period of five or six years during which the secession—it was nothing less—of the United States from the membership in the league, to which we were committed by every test of world expectation and our own good faith, undermined its vitality, palsied its arm, and (*Continued on page* 445)

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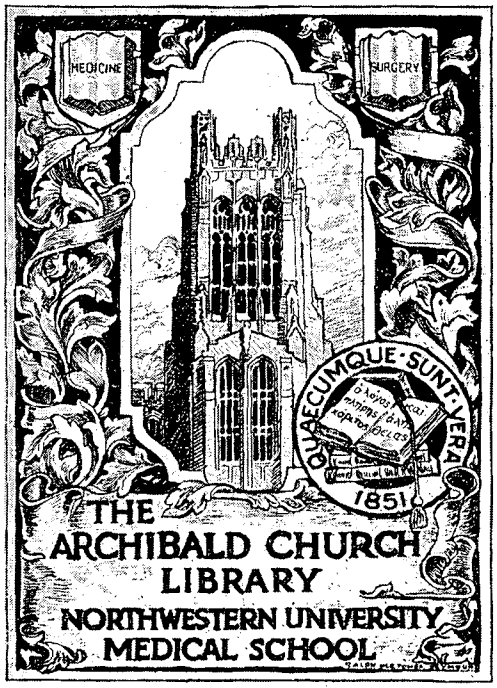
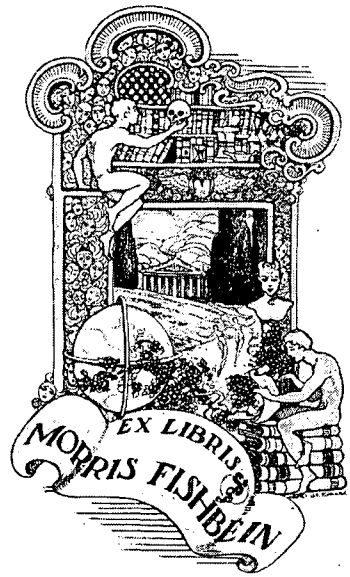
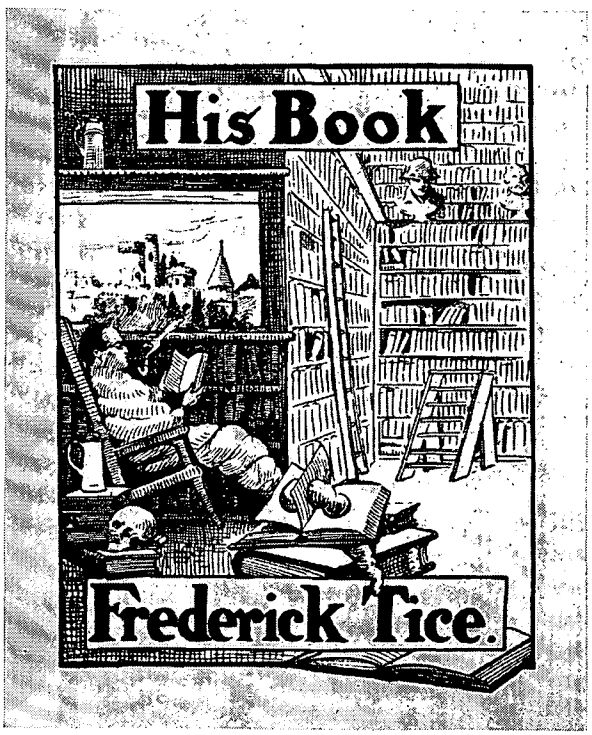
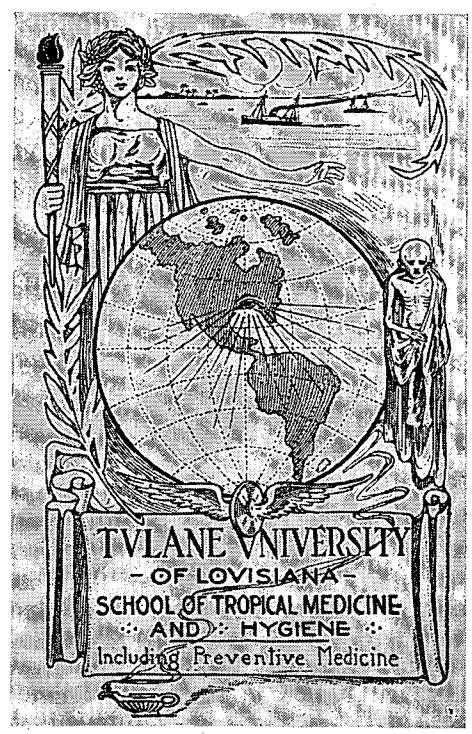
Medical Bookplates

MORE than five hundred bookplates of physicians and medical institutions were displayed in Chicago during November by the library of the College of Medicine of the University of Illinois. We are indebted for selections from that rich store to Margaret Lovell Plumley, assistant to Michael M. Davis of the Julius Rosenwald Fund.









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Letters & Life

In which books, plays and people are discussed

Edited by LEON WHIPPLE

Toys for Demos

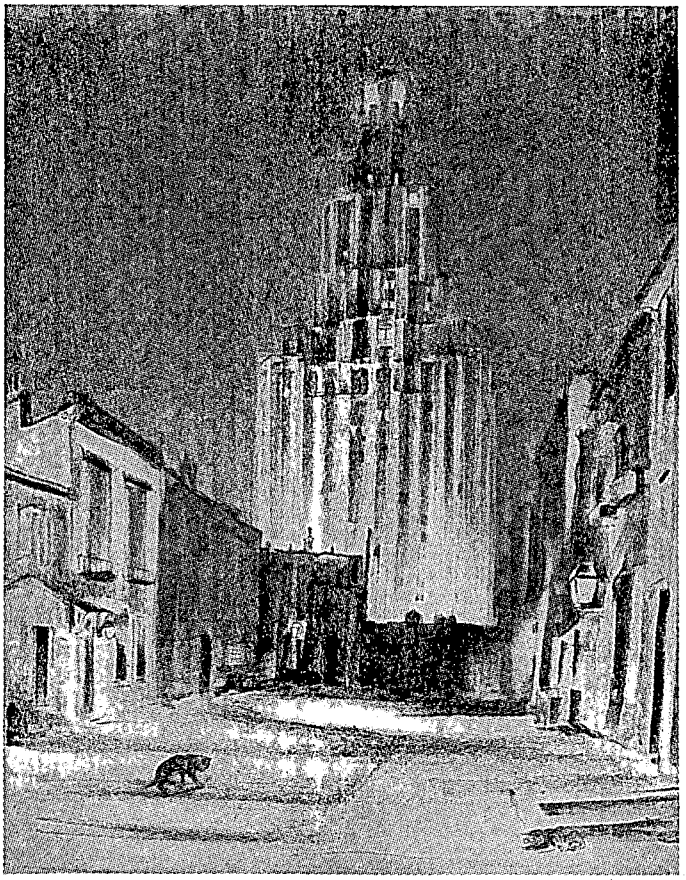
IS this the Age of Woolworth? Is the culture of the Demos revealed at the Five and Ten? I pray not, but there be portents . . . and Woolworthian hath the noble sonority of Elizabethan. Note, then, that this December appeared amid the *bijouterie* of the 2,100 red-front emporia four new ten-cent magazines—The New Movie, The Detective, The Home, and The Illustrated Love Magazine. In the New York stores vast piles melted almost overnight; perhaps a million copies were distributed through these United States. The movie magazine was gone ere my own quest began, become now, I suppose, a collector's item. This was the birth, engineered by the Tower Magazine Corporation, somehow interlinked with the parent Woolworth chain; and I prophesy more millions will be sold month by month. For here ready-made is the distribution system most popular magazines have to erect at high cost, and an audience for advertising of those buying women who populate the Five and Ten. I note already an ad of the Chevrolet car. There is gold in those pages!

There is also a deal of pewter, as reading reveals. But signs of promise, too, so it will not do to high-hat them. They offer aid to the diagnosis of Middletown, U. S. A. For here is standard goods for standard people with the significance of a species in its natural habitat. They are designed to meet an existent demand as surely as the cosmetics, tools, and notions next them meet the Woolworthian demand. What sorts of readers frequent these aisles? By and large, I think, just folks, bewildered yet aspiring, who think they can buy dreams and illusion and forgetfulness as they hope to buy beauty in a vanity-case at Counter 22. It's an old race; these magazines are not new, just epitomes of our present modes, literature of escape and guidance such as the populace has always craved. Those who lament that we are going tabloid should read that recent fascinating book, Forerunners of English Newspapers (1476-1620), by Martin Schaaber (University of Pennsylvania Press) and learn how people craved sensational reading three hundred years ago, tales of love and murder, catastrophe and witches from the new-born printing-press. The literature of wonder we have had always.

Inside these tinsel covers are 128 pages in effective format, though the printing is symbolic Woolworth, where desire outreaches purse. The pictures and display are lively beyond academic tastes, but not o'er raw. This is a miracle ten cents' worth—the printing-press is the exemplar of mass-production. The Detective Magazine is not for *connoisseurs* like me; the tales are machine-made, mixing realism with the delicate make-believe of the genuine art. But they reveal the needs of a time-killing generation that has walled itself off from folk-born play. This is sterile but harmless.

Now The Illustrated Love Magazine—one smiles, but the smile is edged with pity. The old hunger and the old loneliness still drive us down the ancient road that led past Eleusinian mystery, astrologist, love-philtres, hope-chests, and the agony column to seek today strange revelations for desire from this odd godmother, the glittering Press. Cinderella Stenographer enjoys vicariously both love and riches; the eternal representative lover is queerly incarnate in Lindbergh and H. R. H. the Prince of Wales; the 100,000 letters to an editor for the love-lorn reveal that girls are still girls; the lottery of marriage is foreshadowed in How to Select a Husband by Numerology. But this is not sex: this is The Quest. Marriage is a mere addendum, and social duty the echo of a grouch; *this* moment we seek young passion, moonlit bliss, mystery that makes immortal Aucassin and Paolo, Beatrice and Guinevere . . . and a kiss the common language of us all. Who will may throw stones at The Love Magazine, not I, before the splendor of this undying fire. Maybe you think this is cheap and blatant; maybe the young think you cold and antique. Dame Nature is the arbiter.

The Home is the perfect deduction of the tastes of millions of American women: fashions, housekeeping, a film guide, beauty, money-making, home-building, health . . . and fiction. Some big names, Fanny Hurst, Faith Baldwin,



From New York Is Like This, one of the most delightful of the season's gift books, with text by H. I. Brock and illustrations by J. W. Golinkin. (Dodd, Mead, $6.)

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Will Irwin debating Inez Haynes on marriage. Homer Croy, gently bemused about How Late Shall a Girl Stay Out? Tucked in are real matters: the child and the dentist, the problem of an adopted child, or how a girl feels to a stepfather. But these last seem empty, sentimental, playings with unknown deeps. The essences of character and domestic relations are never touched as they are in the keen tales of Eleanor Wembridge. In evolution the task of these magazines seems to be to put questions into people's heads and leave a deposit of information, perhaps wisdom, *en passant.* The rest is sugar . . . with the chance that the false picture cancels the true.

The editing is a superb avoidance of offense to our general mores: the licentious has no place, though things are dressed up with zippy titles and given a "kick" that belies their essential decency. Such conformity procures a kind of selective unreality. It is a dangerous purity that leaves vast areas of life to silence—the graver art, religion, sex. The American folk is in a curious dead-center between science and mythology, reality and illusion. The scientific mood is widespread, so we refuse fantasy or pure myths. We like to feel we are facing real things, yet do not face them; we dig up situations that other ages carefully forgot, or turned over to religious optimism and then refuse the bitter travail of making terms with our universe. Reconciliation with this terrible indifference is slow and dangerous; so it is perhaps a self-preservative instinct that makes plain people dress up with illusion the reality they have at least had the nerve to confront obliquely. The trend is clear in the pictures these magazines use, not the imaginations of artists, but posed photographs. You see?—real but not true, misleading by surface verisimilitude, but empty of spirit, with play-actors in near-tragedies.

Is it a wonder the audience is confused, or rushed back to the certain things—success, health, possessions, clothes, leisure, efficiency, the native gods? These magazines, and many of prouder origin than a red-front notion-store, are concerned with materialisms. They deny the spirit, because science that gave them toys and comfort laughed at religion. Now science consorts with its own new mysticism, but the people have nothing, nor faith nor art nor pagan joy—only trinkets, the trinkets of the Woolworth Age . . . including print!

ONE new toy—or is it herald?—has come, as we knew it would, the movie newspaper. Editions appear hourly on the screen of the Embassy Theater on Broadway from eleven morn to midnight for an endless succession of audiences. The subscription price is twenty-five cents. The hour's program is entirely news reel cinema with sound, and less offensive sound than most. Everything here is real and spot-news, even the sound of the shot aimed at the crown prince of Italy and his Belgian bride, caught eternally in the recorder. Too real, and suggesting grave problems as to invasions of privacy, was the confession of a boy murderer seen on the screen, and heard telling the district attorney his pitiful tale. No compromise between truth and fake there—but heart-breaking tragedy. Mr. Fox and Mr. Hearst were too zealous, but I cannot help thinking the obvious folly of this love-crazed youth may have had deep meaning for the casual crowd. It was terrible, and terror purges. The other thrill was hearing-seeing (what new word shall we use for that twin-act?) Ben Lindsay movie-tone his will. His claim that courts should admit such picture wills to probate and would be guided by the actual appearance of the dead man in court, may be far-fetched but this, as did many a thing in the show I saw, opens up vistas. The dead can now leave voices and souvenirs that may change our forgetfulness or assuage our grief. I do not guess which.

Not everything was of this super-sensational sort—yellow cinematism. The four candidates for mayor of New York had five minutes each, and some got laughed at for their bunk. The talkie has an uncanny power (*Continued on page* 436)

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What Medical Care Means to the Millions

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(*Continued from page* 434) to sift a man and leave his character embarrassingly naked to the public view. I liked the squish of bare-legged French peasants treading out the grapes for wine; and the wind of a Lake Michigan storm was real enough to give you chills. The show is crowded all day on Broadway, a kind of cheap pick-me-up, or a place of regular resort for those who, like me, want more and better news reels, to enjoy curious glimpses of life, travel, adventure, ceremonial shows, and daily drama. It's better than the tabloid. But I doubt whether the all-newsreel show finds support outside large cities. Elsewhere, let us pray, these interludes may crowd off some of the melodrama and bilge now projected.

The prospect that truly thrills and threatens is the home televisor for newsreel or actual events. Going to the newsmovie becomes a chore. Who will not welcome life's daily parade across a radiant screen from his fireside. Newspaper, book, theater, sports—beware that day!

The educational opportunities are enormous; the supply of world-wide current events of interest inexhaustible. Right now I want to see the new front-drive car in action, and certain experiments in electronic physics and visit a planetarium! The editor can use all his ingenuity, wisdom, and taste. Equally astounding are the chances for publicity and propaganda. Mussolini appeared on every program at first—propaganda, or just news value in a picturesque gentleman? The navy has long been showing off its wares. The age-old problems of the press, morals, taste, partisanship, all bob up here. Demos has a new toy, but it may be turned into some Frankenstein's monster, potent to condition us, and to mold our ideas or certify our prejudices. Who shall open and close this window on the world? What chance has the abstract, say peace or justice, to secure vivid and pictorial form to compete with the thrillers?

Indeed, we need to ask what kind of people and what kind of a civilization is being beaten out by these ceaseless impacts, from cinema, radio, newspaper, magazine. We may have invented machines that are as dangerous in peace as our innocent airplane and dyes proved in war. It is high time we took inventory of these playful influences, the powers that control them, and the artists or craftsmen who supply their materials. The people need standards that teach what is wheat and what is chaff. Otherwise they may be enslaved through their own herd passions. Where in this welter are standards of values or ideas of meaning?

LEON WHIPPLE

"The Proud Man's Contumely"

DON'T CALL ME CLEVER, *by Lawrence Drake. Simon and Schuster. 351 pp. Price $2.50 postpaid of Survey Graphic.*

I DON'T know who Lawrence Drake is. The publishers' announcement says he has lived in eight large cities of America, in at least seven cities of Europe, not one of them in Russia, and that this book was written in a Paris hotel. Unimportant, all of it, to this novel. For the god from the machine in Don't Call Me Clever is a Russian small-town Jewish quarter, and the figures which it has marked are Russian Jews transplanted to the German-American community of Milwaukee in the days of Percheron brewery horses and gas lights. What then of some consequence about Lawrence Drake? He writes a first novel as if he were an experienced craftsman of the new school. He delineates the characteristics of the transition Jew as only a Jew can. He resents them as can only a Jew, an uncomfortable Jew.

In a tersely written, brief book, which moves with the heat of an intense quarrel and where every page says something to effect, we have an arraignment of first-generation Jews in America, mainly through their conversation and actions. It is arraignment because there is not an alleviating spark of good humor in the novel. All the more because the author knows no pity the reader is swept with pity— (*Continued on page* 438)

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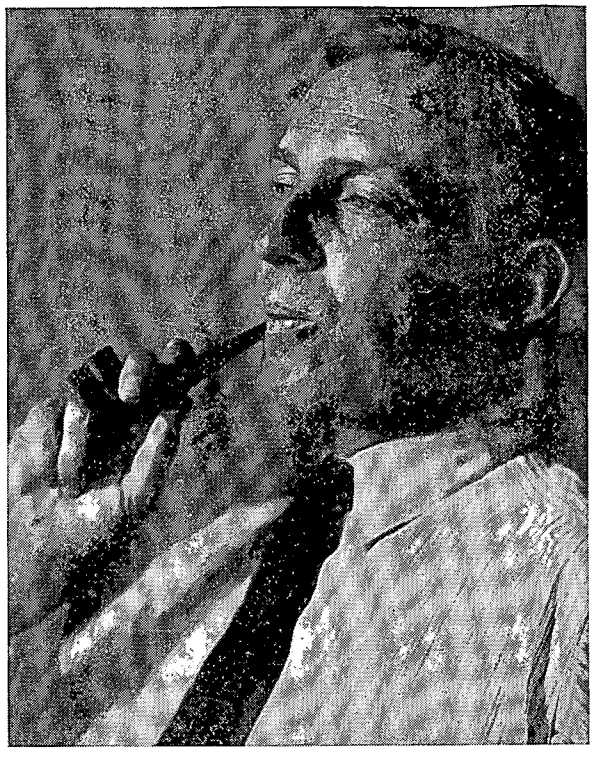

THE BOOK OF ARTHUR GLEASON

"MY PEOPLE"

By ARTHUR GLEASON

"A. G."

By HELEN HAYES GLEASON

THE man who in wartime forecast the tremendous swing of the past decade in British life, turned his scrutiny to the oncoming American. "The world has made a fresh start and he is on hand in plenty of time," he wrote. "If one generation of youth will carry its undefeated purpose through the span of years at the pace of its flying start, we shall release a force and beauty into time, surpassing former things."

To celebrate and illustrate that faith is the purpose of this sheaf of little essays. Its lyric prose treats of the facets of American impulse; its rhythms are as various and contrasting as the jets of nervous vibrancy in Manhattan Nights and the drumming undertones of Ramskapelle Barnyard.

THE author of "My People" was essentially one of them, a lover of tolerance, a hater of repressions and violence. He challenged the hazards of freedom. There was in him that unconquerable spark of the spirit of life, youth that rides the flow of events, the creative artist. Of these Mrs. Gleason writes, and especially of his quest for beauty, the beauty of simplicity, of truth, of suffering.

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(*Continued from page* 436) for the crafty, fawning, successful, devoted older brother no less than for the tortured, intellectual, introspective younger brother. And equally for every minor character, slovenly older women and young mistress, mishandled children, smaller men who are tools of the more shrewd. The four Christians in the book offer a relief. They are serene; they are socially secure—one may dismiss them without concern.

I see this as a kind of Jewish Hamlet, a tragedy for those —author, characters—for whom "the time is out of joint," but must be set right. They charge against the foe. It is invisible chains of the ghetto they are charging. They destroy themselves, men of action and intellectuals, the one by sycophancy, the other by introversion.

Why charge? Why even contemplate? To mix Shakespeare, "Hath not a Jew eyes? hath not a Jew hands, organs, dimensions, senses, affections, passions?" apart from his Christian contacts? Must we always have a thematic novel about the American Jew? Or the Negro? Or the Indian, or any other race?

FLORENCE LOEB KELLOGG

Enter the Queen Again

QUEEN ELIZABETH, *by Katharine Anthony. Knopf. 263 pp. Price $4.00 postpaid of Survey Graphic.*

IT is often stimulating to compare biographies upon the same subject, or to contrast the treatment at various hands. Earlier in the year we had Strachey's Elizabeth, now she is accorded a further interpretation by Katharine Anthony. Each of them, Strachey in particular, takes the modern attitude of the historian in evoking episodes so charged with drama that it satisfies argument. Miss Anthony achieves this in milder degree, being in the main content to set down the facts, plain and unadorned, that survive a Queen's career. Consequently she stays true to her historical principles, though the result might seem to some less satisfactory than the Strachey book, since it somehow lacks the special lustre that comes when the emotions are led into a state of heightened sensibility toward the subject.

Miss Anthony prefers to be simply the historian and thus eliminates other issues not strictly factual. Or possibly such comment as this has little to do with the actual content, the virtues or the defects, and it may seem captious to cavil at a book which so obviously bears all the marks of clear and careful exploration into recesses long musty. Yet—for it becomes difficult not to identify this biography with its contemporary of a season ago—in Elizabeth and Essex prose rises to the level of the period itself, as if by some secret alchemy, not unlikely through the coloration of Strachey's own temperament, and the Golden Age quickens again in his words. Whether his account be accurate, or stained with imagination, there glows like mediaeval glass, the fragments of that epoch, welded by an artist as well as historian, into the brilliant, wayward figure of another Fairy Queen.

Both writers are interested primarily in analyzing the traits of that arresting and elusive personality, hence each brings to bear upon it all the tools and craft of a psychological technique. Miss Anthony has no slight equipment in any direction—her bibliography includes a formidable list of authorities and references; neither is there lacking archaic evidence to support her statements or to lend weight to the values she derives from her examination into the neurotic constitution of England's Queen. Her manner of approach in such instances, has a quality of sensitivity that is seldom met with, balanced by scrutiny bred of a cool detachment.

Character and destiny, for people as well as for individuals, constitute the vital forces which make history. These Miss Anthony reveals, by tracing both the inner and outer sequence of hidden elements, as subtle as intricate, that combined to form Elizabeth's character, viewed in relation to her actions. There is no other wealth but life, it has been said, and life was indeed enriched in her reign. Thus it descends to us, sparingly, almost meagerly, in this new biography. "Among

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all kinds of honorable pleasure," said Brantome, "the Queen of Navarre excelled in making weapons grow rusty while wits grew bright." So it was with another Queen. HALLE SCHAFFNER

Downfall of the Habsburgs

THE DISSOLUTION OF THE HABSBURG MONARCHY, *by Oscar Jaszi. University of Chicago Press.* 488 *pp. Price* $3.00 *postpaid of Survey Graphic.*

THE onetime minister of minorities in the Karolyi cabinet gives us a postmortem report on the sickness and death of the Dual Monarchy. Eminently fitted for the task from twenty-five years of active participation in the affairs of the Empire, Dr. Jaszi has written a richly informing work. His was one of the few voices that long cried in the wilderness of feudal privilege for reforms which he believed would forestall calamity. Just prior to the World War he published his program in a comprehensive volume. After the war in Karolyi's cabinet he was given a chance to put his solutions into operation. But, he tells us, it was too late. The situation was beyond help. So the reformer writes the sequel to his earlier work in this autopsy.

Postulating a voluntaristic theory of history instead of a deterministic one, the author holds the dissolution was due neither to mechanical forces or diplomatic intrigues, nor the World War, but to social agencies that might just as well have been directed to the integration of the Empire as to its undoing.

The basic difficulty of the monarchy was ethnic diversity with the historic traditions of each nationality hostile to the others. A German minority of a little over one third dominated eight nationalities in Austria while a bare majority of Magyars ruled seven groups in Hungary. The hegemony in both instances was directed to organic unification, at first for the Empire but later against it, instead of toward a practical autonomous confederation of the various nationalities. Forces, including the dynasty, the army, the aristocracy, the Roman church, the bureaucracy, capitalism, socialism and free trade, which were essentially centripetal in nature, tended eventually to become centrifugal in effect. The Austrian bureaucracy, for instance, absorbed so many persons of the various national groups that it was transformed into an anti-Habsburg influence. Socialism likewise instead of promoting class solidarity split along nationalistic lines. The customs union bred monoplies that turned free trade into an exploitative and disintegrating policy.

Magyar and German hegemony established in their respective states by constitutional compromise concealed the germs of unavoidable crisis. Austrian feudalism grew increasingly bureaucratized and Magyar bureaucracy became more and more feudalized until the compromise cracked and brought the two Kingdoms into conflict more severe than the internal antagonisms of the nations within each. Then came the Hungarian-Croatian clash, adding a third conflict situation, which stimulated the Jugo-Slav irredenta and precipitated the World War. So the death thrust was given the old monarchy, hopelessly paralyzed from dissention.

Such in bare outline is the complex process traced. The treatment is schematized under such topics as historic background, centripetal and centrifugal forces, irredenta and efforts at civic education. The work would have gained much by condensation of its verbose and elaborate style. Withal the work is a terrific indictment of the Habsburgs and the feudal regime. Still, not many social scientists will accept the author's voluntaristic theory and agree that the course of the Empire could probably have been directed to very different ends.

Oberlin College NEWELL L. SIMS

New book club cuts price of month's leading books to 42c

by Arthur K. Whitley

NEVER before in the history of book publishing has there been so wide and varied a deluge of important—really significant—books. A recent list of best-sellers includes such names as Julian Green, Susan Ertz, John Galsworthy, Hugh Walpole. There is no doubt that American readers want good literature, and are willing to read any amount of good books—if they are within reach.

But so many books are published each years that it is almost impossible for the average reader to buy every volume he would like to own. As a result, hundreds of worthwhile volumes are overlooked—due to the "high cost of literature."

Why are books so expensive? Why can they not be sold as cheaply as magazines? This has long been the problem of a group of distinguished writers, educators and publishers.

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And so the writer, educator and publisher conferred with printers, artists, distributors—*and worked out their plan.* The result is: *Paper Books.* This is a wonderful new book club that provides one outstanding volume a month—12 important, notable books a year—for the unheard of price of only 42c a volume! The books average 300 pages and contain as many words in as large type as the average $3 or $4 book.

Thousands upon thousands of readers who never dreamed that fine books, beautifully designed and printed, could be sold for only 42c a volume, have already become charter members. After subscribers received their first two selections, "The Golden Wind" by Takashi Ohta and Margaret Sperry, a fascinating novel, and "Frederick the Great" by Margaret Goldsmith, a vivid, *full length* biography—letter after letter came to the Editorial Board expressing amazement that such a publishing feat could have been accomplished.

The New York *Times* writing of the first Paper Book selection says: "Not only is 'The Golden Wind' remarkable for a most unusual and successful blending of East and West in romantic narrative, but its selection marks it as a portent in American publication. With cover and end-papers designed by Rockwell Kent, it is a distinguished piece of work, compounded of good paper, clear type and well bound."

Another *Paper Book* selection is "Dewer Rides" by L. A. Strong. This novel created a sensation in England where it received greater praise from critics than any other novel in recent years. Selections like these more than justify the original plans of this remarkable new book club. Now everyone can enjoy a whole year's distnguished reading—*for less than the price of two books;* and still have sufficient in their book budget to buy other volumes that may interest them.

Some of the men responsible for this wonderful new publishing innovation are: Padraic Colum, author, Everett Dean Martin, distinguished educator, Lincoln Colcord, eminent critic, Louis Untermeyer, outstanding American editor, poet and critic, Horace M. Kallen and Charles Boni.

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But even more than that, in a cozy, spacious room you will meet human beings who have a healthy curiosity about racial, national and other differences, and who appreciate the value and need of friendly, informal exchange. For instance, the writer met a Greek newspaperman who has a working knowledge of about a dozen languages, including Persian, Arabian, Turkish and Hebrew. He originally read Homer in Greek, more recently in English, and said, "It was not the same." He spoke of siding with Bertrand Russell that modern education is a failure; and charged it with much of the prevailing crime. As a child of eight or nine, he was taught the finer stories of the old and new testaments and of the philosophers at school. "That gives character and ideals to a boy," he said.

About Conferences

IF ever a show of hands could count, it is in these pre-London conference weeks. In this connection it is impossible to overestimate the sentience, sincerity and service of the women's peace organizations, under the leadership of Mrs. Carrie Chapman Catt. Thus auspiciously, they are holding their fifth annual conference on the cause and cure of war in Washington January 14-17, and have invited representatives from four countries: Miss Kathleen D. Courtney, secretary of the British Women's Peace Crusade; Frau Dorothea von Velsen, president of the German League for Equal Citizenship for Women; Mme. Marie Louise Peusch of France, vice-president of the International Federation of University Women; and Mrs. Tsune Gauntlett, one of the pioneers of the Japanese women's peace movement.

PANAMA CITY will be the headquarters of the second annual congress of the Pan-American Medical Association, January 30-February 5, which will concern itself chiefly with the control of tropical diseases. Many prominent physicians from Latin America and the United States will attend. Dr. William Mayo, Dr. Harvey Cushing, Dr. Simon Flexner, Dr. Llewellyn Barker are among the delegates from this country. The sessions will be held at the Gorgas Institute.

AMERICANS have been lured far and wide by musical events. But how many of them know of the ferment going on here at home? For instance, Chicago, more specifically the Stevens Hotel, will be the scene of the Music Supervisors National Conference March 24 to 29. One of the main subjects will deal with the mechanical developments in music, like the radio and "talkies." In addition to the conference concerts of the National High School Orchestra of 300 players, and that of its chorus of 400 singers, Chicago will be host at a number of musical occasions, principally a concert by its Symphony Orchestra, with Dr. Frederick Stock conducting. Incidentally, the merit of the N. H. S. Orchestra can be gleaned from the fact that at their camp at Interlochen, Michigan, last summer, they made six records for the Victor people, including the Second Movement of Beethoven's Symphony I.

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A DOCTOR DIAGNOSES THE BILLS

(*Continued from page* 378)

estate or jewelry or legal advice or anything else which might vary so widely in price. Can it be that "the best is none to good" until the time for payment comes? The noted specialist is entitled to charge prohibitory fees. There is scarcely any other way of restricting his practice to what he can physically do, but he would be glad to refer patients unable to pay his fees to other competent doctors willing to accept the fee the patient can pay—and there are hundreds of them.

In cogitating on what people spend for medical care, another expense which seems to have been overlooked is the amount paid to cultists, quacks and advertising fakes, most of it by the "great middle class." Unlike the doctor, they never temper their charges to the means of their patients, wait for their pay or work for nothing, and the money paid to them is mostly thrown away or worse. Without dilating upon the paradox of a state compelling a college man to spend four years in expensive study, and in some states five, before he can legally treat the sick, and at the same time allowing anyone who has graduated from a highschool or had an "education equal" to it, after a short course in some "college," also to treat all sickness provided he does not use drugs or provided he uses only manual manipulation, the doctor wonders how much the excessive cost of medical care would be reduced if these parasites were exterminated. Surveys are in progress which will throw some light on this question, but at present no one knows.

The doctor has never denied that the cost of medical care is too high. He has been told that it is so often, that in his natural conservatism and lack of knowledge outside his own experience he has hesitated to disagree, but when he looks at his bank balance he is unable to diagnose the trouble as primarily located in the medical profession, though all the "doctors" who have been prescribing for the sick public and treating it have acted on that basis. He realizes that the profession has always been fair game for anyone hunting for something of value for nothing, that it has always been most cooperative in being game for the hunter, that the doctor as game is never out of season and that a hunt is again on. As usual the profession expects to cooperate, but the size of the bag this time is to be so large that it asks and expects the game in the bag to be varied and not all doctors.

PIONEERS PLOUGH A WAY

(*Continued from page* 404)

as at present. In six townships the vote was unanimous and in another, forty-five miles away, it was forty-five to two. Rosetown doctors are equally well pleased with the arrangement, for it helps assure them a hospital to work in and makes their bills easier to collect by eliminating high hospital costs. Hospital authorities also favor the plan because all of the patients' accounts are promptly paid and there is no deficit.

The principle which underlies all of these plans—that of spreading the cost of sickness over the whole community—has been applied to the entire province in some degree by Saskatchewan's hospital and maternity grants. Under the terms of the first of these, the provincial government pays each of the fifty-odd accredited hospitals and the fifteen Red Cross outposts fifty cents a day for each patient. Thus if a patient is in the hospital for ten days, the government pays the institution five dollars toward his care. While the amount is not actually deducted from his bill it nevertheless decreases the amount indirectly. Furthermore, the province and the municipalities jointly pay all the cost of treatment for tuberculous persons who apply to the Anti-Tuberculosis League. The maternity grant amounts to $25, and is paid to any indigent woman before childbirth. With it she is to (*Continued on page* 448)

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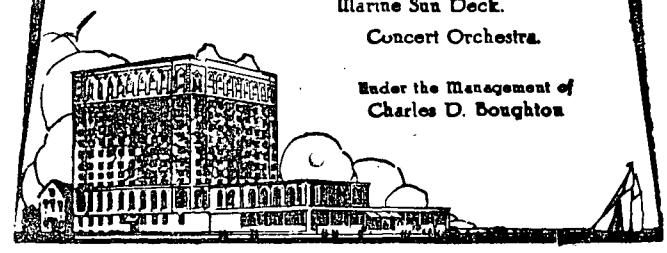

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PARLIAMENTS OF PERSUASION

(*Continued from page* 431)

might indeed have wrecked it. That period has safely passed. We are as yet only bushwacking around the edges of participation, though a large number of Americans have taken part in one way and another in league activities many of them directly commissioned thereto by the government of the United States. Just now we are in a stage of a more or less jealous rivalry, in which our posture is, to say the least, none too dignified.

The importance of the so-called Kellogg Pact lies chiefly in its complete commitment of ourselves to the policy of pacific settlement of international disputes. In fact, it simply embodies for ourselves and the other signatories the standard to which the league has been committed from its inception. It is a feeble thing compared with the Geneva Protocol of 1924, our own and Great Britain's adherence to and compliance with which would have made war anywhere impossible. Yet even with that protocol and observance of Article X of the Covenant, at which our politicians piously balked, the league would not have had the "teeth" demanded for the "League to Enforce Peace," which, as lately as the summer of 1916, Mr. Taft, Senator Lodge, President Lowell, Mr. Gompers, and others, so ardently advocated—before this business took on its lamentably partisan aspects in our domestic politics.

Going it alone, as several times we have tried to do, has brought us little glory. The last episode in that activity got us a slap in the face. That it came from Russia, chronically bad-mannered in diplomatic correspondence, is of little comfort. In absence of reliable information about what has been going on in Manchuria it is risky to generalize; but it looks as if we had butted in tardily and superfluously upon a process of at least nominally amicable settlement. In any case, it becomes increasingly apparent that the world public opinion which the league has fostered—not quite to say created—in favor of settlements by conference and compromise has tended to smother that threatened fire in the East; to make all nations ashamed if not afraid to neglect that procedure.

MR. HOOVER, of whom it was to be expected, has afforded an example of this technique and spirit in calling for an investigation of affairs in Haiti. It was more than high time. It ought not to have required a bloody outbreak there to emphasize the necessity for a complete overhauling of our relations with that unhappy nation, where our bayonets have maintained to all practical intents a military despotism. Even a superficial investigation by a fair-minded commission, will disclose a situation defiant of every fundamental of American tradition. Our "mandate" (so to call it), in Haiti was self-assumed; but it is platitudinous to say that of all people on earth we ought to be governed in such enterprises by policy and accountability at least as strict as that imposed by the league upon supposedly "advanced" nations entrusted with supervision over so-called backward peoples. The story of our rule in Haiti is one that no American will enjoy having told in the ears of the world. It will show how far we have fallen short of the standards the league would set for our guidance.

SO, if in somewhat different fashion, does the uproar in Palestine exhibit the consequences of evasion of those standards. Great Britain, in exercising her mandate over that distracted area, has wobbled between sovereignty (which was not conferred) and a cynical negligence. It is precisely her business to protect that little country (about the size of New Jersey) from being the arena for fighting-out of issues concerning Egypt, India and other regions whose problems are far different; or for the activities of hot-heads and professional racialists there and elsewhere—including the United States of America. All cool-headed Jews and Arabs know that Palestine cannot belong to or be controlled by either race exclusively; that the only hope lies in getting together in the "spirit of Geneva," of the parties there resident, to work out a bi-racial *modus vivendi* fair to both sides. This is within easy reach if outsiders could be chased out of the picture and the business confined to those whose business it is; namely, the people, Jews and Arabs alike, who live in Palestine. Great Britain has shown both disposition and ability to do this in the case of Iraq, which she is now endorsing for independent membership in the league.

Dr. Judah Magnes, chancellor of the Hebrew University, displayed characteristic wisdom and courage in endorsing the declaration of St. John Philby, famous as a disinterested friend of the Arabs, in favor of neutralizing Palestine as a territory "sacred to the three great religions." It is altogether in the "spirit of Geneva" that Dr. Magnes said:

> If Jew and Arab are to live together in Palestine it must be as an act of faith—of faith that they are brother peoples, and that they can rise above their weaknesses and their passions. . . . The Eternal People should rather continue its long wait than attempt to establish a home in the Holy Land except on terms of understanding and peace.

Naturally the irresponsibles are enraged by this exhibit of mere sanity. Some of them have pronounced Dr. Magnes's avowal "untimely;" have declared that his position at the head of the university estopped him from expressing any opinions whatever. Quite the contrary. There is sore need of just such words from just such men. There could be no better time than now to talk sense in and about Palestine, or any other place where good sense and good spirit have been lacking. It is particularly appropriate just now, as we celebrate the success of those things in the ten years' history of the League of Nations, so fast becoming the custodian of the world's peace; the best expression and exponent of the world's common sense.

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AMERICAN GENETIC ASSOCIATION, INC.— 306 Victor Building, Washington, D. C. "To promote increase and diffusion of knowledge concerning Heredity". Publishes monthly *Journal of Heredity*, which gives announcements and discussions of recent discoveries regarding heredity—with ample illustrations. Membership composed of research geneticists and leaders in many fields, teachers, physicians, clergymen, lawyers, etc. The Association is anxious to learn of cases of identical twins reared apart, which give unique opportunities to study effects of heredity and environment. Membership dues $3.00 per year.—Sample copy of Journal of Heredity and circular illustrating heritable characters sent on request.

ART EXTENSION SOCIETY, INC.— The Art Center, 65 East 56th Street, New York City. Purpose,—to extend the interest in, and appreciation of, the Fine Arts, especially by means of prints, lantern slides, traveling exhibitions, circulating libraries, etc., etc.

COMMISSION ON INTERRACIAL COOPERATION—409 Palmer Bldg., Atlanta, Ga.; Will W. Alexander, Director. Seeks improvement of interracial attitudes and conditions through conference, cooperation, and popular education. Correspondence invited.

THE LEAGUE FOR THE ORGANIZATION OF PROGRESS— affiliated with the International Institute for the Exchange of Social Experience aims to establish a higher civilization of mankind by synthesizing the social institutions and cultural achievements—the ripened fruit—as it were—of each National civilization. Its organ, "Records of Progress," a quarterly magazine, printed in French, English and German, with an International News Bulletin, "Political Letters," reports on all phases of human progress, legal, political, economic, educational, artistic, hygienic and moral, to make humanity conscious of its interests. Subscription $2.00 (Students $1.50) With Political Letters $3.00 Dr. Rudolf Brodo, president, Yellow Springs, O.

LEAGUE FOR INDUSTRIAL DEMOCRACY—Promotes a better understanding of problems of democracy in industry through its pamphlet, research and lecture services and organization of college and city groups. Executive Directors, Harry W. Laidler and Norman Thomas, 112 East 19 Street, New York City.

THE NATIONAL CONSUMERS' LEAGUE is an educational movement founded in May, 1899, to awaken consumers' interest in their responsibility for conditions under which goods are made and distributed. The joint candy white list is the most recent development. Dr. John R. Commons, president; Mrs. Florence Kelley, general secretary; 156 Fifth Avenue, New York City.

NATIONAL COUNCIL FOR PREVENTION OF WAR — Frederick J. Libby, Executive Secretary, 532 Seventeenth St., N. W., Washington, D. C. Aims to stimulate the movement against war and to increase the coordination of peace forces. It stands for progressive world organization, worldwide reduction of armaments by international agreement to police status, and worldwide education for peace. Subscription to "News Bulletin", 50 cts. a year. List of publications free.

NATIONAL WOMEN'S TRADE UNION LEAGUE OF AMERICA— Mrs. Raymond Robins, honorary president; Miss Rose Schneiderman, president; Miss Elisabeth Christman, secretary-treasurer; 311 South Ashland Boulevard, Chicago, Ill. Stands for self-government in the work shop through trade union organization; and for the enactment of industrial legislatiin. Official publication, Life and Labor Bulletin. Information given.

SOCIALIST PARTY OF AMERICA— 2653 Washington Blvd., Chicago, Ill. Clarence Senior, Executive Secretary. An educational and political organization fighting for increasing popular control over social and economic forces. Send stamps for recent leaflets on old age pensions and unemployment insurance.

(*Continued from page* 441) pay the doctor something of a fee and buy needed supplies.

Whether or not these various plans will pass as the country develops and becomes more thickly settled is, of course, a speculation. So far the number of communities in which they are found has been gradually increasing. Likewise the feasibility of trying some of these plans in the United States may be questioned by many. A discussion of that topic is beyond the scope of this article. In this connection, however, Dr. Seymour's opinion is interesting. Public health development in Saskatchewan began with him and developed under his leadership for a quarter of a century. His viewpoint was further broadened by affiliation with a League of Nations commission and his former vice-presidency of the American Public Health Association. "Saskatchewan," Dr. Seymour believes, "has developed an idea that will become increasingly popular with people everywhere who may be finding it hard to get, keep and pay good doctors, hospitals and nurses."

A MERCHANT LOOKS AT MEDICINE

(*Continued from page* 391)

is almost Utopia, and the average doctor cannot do much about it now, except to study business evolution and to do his bit in enlightening those with whom he comes in contact in his daily practice.

In the meantime, it seems to me, some progress could be made through the setting up of clinics and health centers, not as charities, but on a strictly competitive business basis. We speak commonly of competitive business as *private* business, but this is a misnomer. The Ford Motor Company is competitive; but because it has the benefit of all the economic checks of competitive business, it is more public in character than are many government departments. That is, it serves the public better, and it answers more readily to the public's needs. It does this because it had to. Ford got out Model A because he had to. If he had been a government, or a charity, Model T might still have been "good enough."

There is every reason to believe that our hospitals, good as they are today, would be vastly better if they had to be. This is no reflection upon the men who run them, nor upon their integrity and devotion. It is simply a fact which business men are coming to appreciate more thoroughly every day, that one does not know how much service it is possible to give for the money until he is confronted with the necessity of meeting a competitor. That is why I proposed, in an address before a medical association, that doctors would do well to organize as business institutions—ten or fifteen, perhaps, in a single company—to merge their knowledge, to reduce their overhead, to provide every member with the best and latest in equipment which medical science has devised, and to place all these advantages at the service of the public, not at prices which seem either good or merely "reasonable," but at prices which, upon objective analysis, it is found that the public can afford to pay. That there would be profits, real profits, perhaps hitherto unheard-of profits in such a healing business, I have every reason to believe.

I do not believe, however, that the principle of maximum service to the community is likely to be best worked out through paying first attention to its mechanics. It is the *principle* which must be given first attention—the mechanics will follow; and the principle is the principle of serving the greatest possible number at the lowest possible cost.

Now, every doctor knows that it is less costly to stay well than to get well after one has broken down, just as it is more economical to keep one's car in good condition than to wait until it falls to pieces on the road. The doctor, then, who wishes to give maximum service, will give first emphasis to preventive measures; not merely agitating the idea of regular consultations, but organizing his resources (and his prices) in such a way that large numbers of people will consult him regularly for the specific purpose of keeping themselves in good running order. When doctors generally get that idea, competition will do the rest. It will compel combinations and the merging of resources, and a constant searching for better methods of giving greater values for the price.

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